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MODERN PSYCHOTHERAPY

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PREFACE

Psychotherapy is a term which has been somewhat loosely used. For the present purpose it is taken to include all methods of treatment which are dependent upon psychological processes for their origin, and which also aim at assisting the correct adaptation of the patient to his environment without the use of such physical methods of treatment as surgery, or the administration of medicine in whatever form.

Psychotherapy is such an elusive subject that it has been extremely hard to write a monograph which is of some practical use, and yet simple to understand, as this form of treatment depends so much on psychological theories of which there are several different schools of thought and about which we still know comparatively little. Nor is it easy to avoid stressing one's personal ideas, theories, and technique. I have endeavoured to give a fair account of the different schools of thought without personal bias, and yet it is almost certain that in the chapter on Analysis someone will feel that I have not done justice to their own particular school of thought. I can only assure them that this is not intentional, but probably results from my own ignorance.

My hope is that this contribution may provide some helpful information for the general practitioner who has to decide which of his patients should attend clinics and specialists for psychological treatment, and that it should help him to be more cognizant of just what that treatment is. In addition I hope that it may prove a useful guide and starting off point for those who are wondering whether they will find the study of psychological medicine interesting and worth while.

Some information which may be of practical value is given in the Appendix, and a Bibliography is included for those who may wish to read the subject more deeply.

I wish to express my gratitude and thanks to my colleagues at Woodside Hospital for their criticisms and suggestions, and particularly to my friend Mr. R. A. Howden for his kindness in reading and correcting the manuscript and proofs.

CONTENTS

CHAPTER		PAGE
I.	Some Modern Psychological Conceptions	1
II.	Analytical Methods	14
III.	Suggestion and Persuasion	39
IV.	Re-education	55
V.	The Explanation of Some Common Problems for the Purpose of Treatment	69
VI.	Occupational Therapy	86
VII.	Factors Determining Method of Treatment Selected	99
VIII.	Child Guidance	119
IX.	Psychotherapy and Prophylaxis ...	136
Appendix		145
Selected Bibliography		146

MODERN PSYCHOTHERAPY

CHAPTER I

SOME MODERN PSYCHOLOGICAL CONCEPTIONS

Few branches of medicine have passed through a more difficult time than psychological medicine has. The old conception of nervous disorders was, broadly speaking, that people suffering from some form of mental upset were lunatics, insane, and should be incarcerated in the nearest lunatic asylum, or, if their behaviour and mental capacity were not affected too much, and they complained only of nerves, it was thought that they were weak willed, had a weak character, or even were malingering. How many patients suffering from their 'nerves' have been told to pull themselves together—the one thing that they have wanted to do, and the one thing that they could not do by themselves. The most common treatment in past times was to give the patient bromide, and many were the poor patients who tried to keep going

on bromide, soaking themselves to the point of bromide intoxication.

I think that it must be admitted that the knowledge of modern psychological medicine is still very limited throughout the profession, and this, after all, is very natural. Until comparatively recently very little teaching has been given on mental disorders, using this term in its broadest sense. It is true that for many years, in order to comply with the medical curriculum, there was the statutory course of lectures and demonstrations on psychiatry, but these were given up almost exclusively to the psychoses, that is to say, the study of the insane. Nothing was taught about the neuroses, or 'nerves,' and yet almost every general practitioner one meets will speak of the high percentage of functional cases he sees in his practice. Even now, in only comparatively few hospitals has any provision been made for a course of lectures on Psychology or psychopathology; little or no insistence is laid on the teaching of the neuroses, and it is left largely to the initiative of the lecturer whether the neuroses are included in the statutory course of lectures with the psychoses. It is no wonder, therefore, that there is still a great tendency to make a diagnosis of "nervous trouble," "nervous debility" or neurasthenia. It might be well to stress immediately that true neurasthenia is one of the rarest of all the neuroses. Moreover, when a diagnosis of some

neurosis is made, more often than not it has been done by a process of exclusion, and it is not generally appreciated yet that many of these conditions can be diagnosed by recognizing their own particular group of symptoms, in the same way as an organic condition such as pneumonia or typhoid can be diagnosed. Having written this, it is only right to admit freely and at once that things are improving rapidly and that the proper authorities have now recommended that the teaching of psychological medicine should have a more prominent place in the medical curriculum. Moreover a considerable amount of post-graduate instruction is now obtainable.[1]

The modern concept of psychological medicine is based very largely on the researches of Freud. It is to him almost entirely that we owe our present knowledge of medical psychology, and the neuroses. A knowledge of modern psychology has enabled us too, to get a much clearer understanding of the insane person, and the principles and motives at work, even though we must admit that this knowledge has not as yet helped us to increase the percentage of cures amongst psychoses to any considerable extent. In the past there has been too great a tendency to think of all illness in terms of inflammation, tumours, infections, and such material problems. It cannot be

[1] *See* Appendix.

doubted, however, that physical symptoms can be produced by phenomena of a disordered mind, or emotional system. The paralysis of say, a leg in hysteria is just as real a paralysis as if the sciatic nerve had been severed, and yet it is produced by a dissociation of the brain, and not by an organic lesion. The tachycardia of acute anxiety is something that all of us have experienced to some degree. If these fundamental facts are admitted, as they generally are now in the medical world, it should be clear that pouring a lot of medicine into these patients is not going to cure, though it may ameliorate the condition. The illness must be treated along psychological lines, and in order to understand the mode of such therapy some knowledge of the etiology and pathology is helpful. We know little as yet about the causation of nervous traits and mental disorders. There is a great deal of evidence to show that it is incorrect upbringing in the early years rather than heredity that causes a neurosis. There is no doubt, however, that certain people seem to have some unknown quantity missing, the absence of which causes them to break down under a stress which would scarcely affect others.

One group of people may develop a nervous breakdown because their early upbringing has been such as to cause excessive repression, and has utterly failed to enable them to adapt themselves to the realities

of life. By repression is meant an unconscious mechanism of the mind by which primitive instinctive urges are not allowed to come into consciousness where they may rankle and cause a conflict with the social ethics, religious views and parental teachings, which go to make up the moral side of our conscious life. In addition this mechanism does, in certain circumstances, remove, so to speak, from consciousness the recollection of unpleasant experiences which are causing the individual unpleasant emotional stress. If the power of repression is strong there may be no further reaction in consciousness, but these instinctive urges and unpleasant experiences are always tending to find either an association with some fact in consciousness or else to protrude themselves directly into consciousness, in which case the same unpleasant feeling of emotion is experienced by the individual. Where there has been excessive repression, it means that the instinctive urges have been dammed back instead of having been modified in a proper manner, and so all this thwarted energy is trying to spread out in some way, much like a dammed back river may overflow its banks and cause trouble. For instance, if a child is brought up starved of the affection of his parents, yet sees his younger brother having love and affection lavished upon him, it is natural that the child should tend to hate his brother, and also show some emotional reaction, such

as aggression, towards the parents. Because of his upbringing, however, and the fact that he is taught to love, honour and obey his parents, and that it is wicked to hate, that hate of his brother must not be allowed to develop in consciousness, and so repression occurs, pushing back, so to speak, the emotion and thoughts into unconsciousness.

Another group of people break down because of excessive mental stress resulting from attempt to adjust to the problems of life and environment. In order to give rational treatment of any condition, it is helpful to understand the pathology and development of the illness. To understand the genesis of the neuroses it is essential to have some knowledge of the theory of the unconscious, for which information we are largely indebted to Freud. Perhaps the simplest, even if it may not be accepted universally as the most correct conception of the development of the child's mind, is to think of the conscious part of the mind developing in the following manner. The newborn babe begins to get sensations from birth, e.g. an uncomfortable feeling inside which makes it cry, and which the mother recognizes as hunger. As the child learns the meaning of various sensations, e.g. that a certain object seen visually is always called a dog it comes to the stage of perception. The perceptions are stored in the memory as images, and when at a later stage, by association and experience, these

various images are reproduced as meaning something which the child can understand, the stage of ideation has been reached. From the time the child has formed concepts of ideas the whole conscious mind continues to develop to the stage of reasoning and judgment, as found in the adult. Needless to say the child gets its knowledge from those around him who bring him up and teach him what is the meaning of the various sensations he receives. He also learns by trial and error.

The unconscious part of our minds is more primitive. In every newborn babe, or animal for that matter, there are certain fundamental urges which form the driving power to our life. McDougall speaks of these as our instincts and Freud terms them the Id, by which he really means that unconscious, primitive mental structure with which we are born. The details of how many instincts there are, or of what this primitive urge really consists, is still under discussion, and this book is hardly the place in which to go into such theories. Broadly speaking, these primitive urges satisfy and promote the two great urges of self-preservation and reproduction. The urges which are most evident in the newborn babe are those relating to self-preservation such as the nutritional, the acquisitive and the self-assertive urges, but it must be realized that the early dawnings of the reproductive instinct with its wide emotional

attachment also shows itself in its undeveloped, infantile form at a very early age as well. Associated with each of these innate urges is a specific emotion, the primary emotions which themselves become intermixed and more complex as development proceeds. These instinctive urges with their attached emotional reactions form the driving and feeling part of our life. Thus we can now comprehend two parts of ourselves, one primitive part driving us forward to action along instinctive lines and giving us a sense of feeling, perhaps of pleasure, perhaps the reverse, while the other part developing slowly provides the intellectual understanding and knowledge of the results of our actions and emotions. Thirdly, one more faculty develops which must be comprehended. It is that process within us which gives us a sense of right or wrong, a sense of social ethics and the correct attitude to adopt. This is the conscience of religion, McDougall's sentiment of self-regard, or Freud's Super-Ego.

It has been clearly shown that if during the development of the child one of these instincts is dammed back, a state of tension and upset results. Most of us have seen the counterpart of this in a dog when a rabbit that it has been chasing has disappeared through a hole in a fence too small to allow the dog to follow. The dog is upset, whining and fretful for some time after. It can also be clearly

understood that when a child is being 'brought up' the instinctive processes are constantly being modified. For instance, the babe is taught how to suck the breast correctly—its first attempt is instinctive, the child is neither shown nor taught how to suck, it is only the improved technique of sucking that is taught. Later it is taught to suck from a teat and bottle, to drink from a spoon or cup, and finally to eat solids. It is taught to eat with a spoon, fork and knife, not to eat too quickly, nor to be gluttonous until the education in how to feed itself is completed.

The primitive instinctive urges of each one of us have to be modified very greatly in accordance with civilization and the environment in which we are living. This can be well illustrated in the reproductive urge. It can be shown that the sexual instinct develops in three phases. The earliest indication of the reproductive urge is when the urge and its attached emotion is turned in towards ourselves. Everyone knows how the babe enjoys self-stimulation, tickling and exposing itself, also how it naturally takes an interest in its own body, and in its own natural functions which it regards with an interested curiosity. During the earliest development of the reproductive urge, the pleasant sensations seem particularly to be associated at first with oral and then anal sensations. The pleasurable sensations which a child has when sucking are clearly recognizable. It

has been shown that some mental abnormalities of adult life can be traced back in certain cases to failure of this phase to develop naturally. As a result of the emotion of the reproductive urge being turned inwards, the child passes through the narcissistic stage; it is he himself that he loves. It is easy to see how during this stage auto-eroticism develops, when the common and natural result is masturbation. If this fact is recognized it will explain why no particular notice need be taken of masturbatory movements in the young child. In the normal, healthy child the narcissistic and auto-erotic phases pass without ever having been particularly noticeable, and then at about eight years old the second main phase begins. This is the homosexual phase when the child is attracted towards members of his own sex. It is the phase when boys show hero worship and the girls 'pashes' for their mistresses. This phase usually continues until puberty or often considerably later. The third or hetero-sexual phase comes into full development from about puberty to adolescence.

Naturally from a physiological and primitive point of view the sexual instinct should now come into its full usage, and mating should occur. However, in civilized countries to-day owing to social economics very few people can get married until many years after puberty, and moreover, according to social ethics the sexual act is taboo out of marriage and so

at once the individual is placed on the horns of this dilemma. Either he must control this urge and not allow this all powerful instinct to be satisfied for many years after its full development, or else the usual urge is satisfied at the cost of a sense of shame, guilt and revolt against social ethics.

It is clear from the above that an individual's natural instinctive urges often come into conflict with social ethics, or are in rebellion against his upbringing and environment. It must not be thought that this modification only occurs with sex. Curiosity is an urge that may be wrongly handled. The emotion of fear is inborn in all of us and needs lessening rather than aggravating, yet many parents tend to discipline their children by fear.

Freud and his followers have demonstrated that certain psychopathological states are particularly likely to occur, and that certain mental mechanisms, which normally are for the purpose of keeping the mind free from mental tension, may become exaggerated to an abnormal extent. Freud has pointed out that if an instinctive urge is blocked during its development in childhood, a fixation may occur at that level, and hinder further natural development of that instinct. For instance, if through faulty upbringing an unwise punishment for masturbatory movements in a child of three or four is threatened or given, a fixation may occur. The libido, or urge

of the sexual instinct which at that age is directed along the auto-erotic phase as just described, may continue to be turned inwards by the child on itself, with the result that he continues to love himself instead of passing on through the normal phases of sexual development. In such a case the child will grow into a complete 'Narcissist,' and his adult sexual life is unlikely to be normal.

The relationship between the children and parents, going back even as far as the breast feeding stage, is very important. The basis of anxiety states, animosity and resentment are often being laid in these early years. Many of the obsessional states are symbolic of a sense of shame and guilt. The mental mechanism of regression, which is the tendency to retire to a childish state, is commonly seen in young children of say, five or six years old, who may lisp and behave in a babyish way when they are up against parental authority. It may be seen in a pathological state in adults. 'Projection' is a mechanism by which an individual, unconsciously, invests others with some emotional reaction which has its root in a repressed conflict too unpleasant to be allowed in his own consciousness. Thus the man who is constantly a failure may be unable to face and admit that fact to himself, and may project the emotion associated with that fact on to his employers, with the explanation that they do not understand him or treat him fairly. This

mechanism is particularly seen in a pathological form in systematized delusional insanity.

These examples, and the fact that the genesis of so much illness of the mind is not caused by any demonstrable physical disorder but by a clash of mental processes, is surely a clear indication that illness of this kind is not going to be cured purely by medicinal means. Of course, anxiety can be allayed by bromide, insomnia can be corrected by a narcotic, but that is treatment of the symptom and not of the cause. The treatment for such illness is, then, one of the methods of psychotherapy. Charcot, Janet and others, many years ago showed the value of suggestion in curing hysteria. Then Freud went more directly to the root of things, attempting to analyse out the fundamental factors which had led to symptom formation. It is with the idea of giving a brief survey of the different methods available in psychotherapy that this book has been written.

CHAPTER II

ANALYTICAL METHODS

So much has been written about 'analytical' therapy that it is as well to get a clear conception of what is meant by the term.

Its rationale is based on the assumption that many of the symptoms of, at any rate, the neuroses, and perhaps also some of the psychoses, are the conscious manifestation of subconscious conflicts. These conflicts may derive their origin from many sources, such as the blocking of instinctive reactions, unresolved fixation, or some psychological trauma, producing an abnormal emotional reaction.

The aim of 'analytical' therapy is to enable the patient to work back through the numerous mental processes of his life, his experiences and forgotten recollections, in an attempt by association to bring into consciousness all repressed material, thus resolving any conflicts, especially all those that pertain to the subsconscious. While doing this it is hoped that any emotional element which has been dammed back may be liberated, thus enabling the patient to work off, or 'abreact' the emotion that has previously been

thwarted. This abreaction is intimately connected with the patient's transference to the physician. The term 'transference' indicates the emotion which is projected by the patient on to the physician. This emotion has its original association with some repressed material, and so the patient may be unaware at first why he feels drawn to or hostile to the physician. This is termed 'positive or negative transference.'

Analytical therapy was introduced by Freud, and his term psycho-analysis is best kept for the technique used by the Freudian school of thought.[1] Adler and Jung both use a somewhat different technique of treatment. Many English physicians use a still more general and variable technique which has been differentiated from analysis by some authorities by calling it 'mental exploration.' The Freudian school maintains that the analysis should be very thorough, and as complete as possible, lasting perhaps three years or longer. There are many psychotherapists who consider a more superficial analysis lasting from three months to a year is often sufficient.

Considerable controversy has raged around the question of which patients are suitable for analysis, and which is the best analytical technique for a particular case. Obviously, a patient will want to

[1] See Bibliography.

avoid a three-years analysis if he can get as satisfactory a result in three or six months. An attempt has been made to deal with this question in Chapter VII.

In the first place a description will be given of one of the methods of 'deep mental exploration' or analysis. This method can be recommended for general use and for a beginner who wishes to acquire an analytical technique. When experience has been gained the beginner, should he wish to do so, can adopt a technique more definitely allied to some particular school of thought. It is not easy to give rule-of-thumb instructions in the description of this form of psychotherapy as the individuality of the patient and the physician can rarely be completely erased and forgotten.

It is a vexed question as to whether anyone who is going to undertake analysis should first be analysed himself. It is obvious that if during an analysis the analyst is going to allow his own emotional reactions to influence him, or to 'project' on to the patient emotional reaction, or if he is going to be upset by a negative transference, then harm will be done to the patient. It probably depends on how well balanced the analyst is. If he is a stable personality with a good knowledge of mental mechanisms, which he can see and recognize going on in himself, an analysis is not necessary; although it is probably the

best way in which to learn the technique, and it is always going to be helpful. If, on the other hand, the individual is a shut-in type of personality, or has undue psychological difficulties of his own, an analysis is probably indispensable. The Freudian school do not consider that anyone is properly qualified to carry out 'psycho-analysis' unless he himself has been psycho-analysed, and has been passed by the Training Committee.

In the technique to be described more attention is paid to the history-taking and medical examination than is the case in psycho-analysis. One or more sessions may be given up to getting an adequate history of the patient's life, and a full physical examination is made. During these sessions good contact should be made with the patient so that he feels that the physician is in sympathy and understanding with him. There is a difference of opinion as to whether the physician should make the physical examination or not. Many physicians when carrying out this technique prefer to make the physical examination themselves, only referring the patient to another man for such special examinations as are needed for, say, some pelvic disorder. It is easy to understand that examination of the pelvic organs might cause the patient some emotional reaction, such as embarrassment, which the analyst does not himself want in any way to provoke.

It is essential to be able to obtain a reasonably complete and yet quick psychiatric history. It is often said that general practitioners have no time to talk to or deal with neurotics. An adequate history, which is essential for diagnosis alone, need not take so long. The following method of history-taking is used by the author in dealing with his out-patients, when unfortunately, the work has often to be rapid. The physician should avoid the appearance of being rushed, even though he may be, otherwise the patient is much less likely to talk freely. It is probably quickest to ask the patient simply to tell the physician all about his trouble. Do not necessarily indicate symptoms, but word your opening remarks to the patient in such a way as to give him the impression that he is not only to talk about symptoms, signs and what he would call illness, but also about any trouble, unhappiness, or difficulty that may be his. It is often far quicker to allow the patient to talk in his own way for a quarter of an hour or so, than to ask questions.

During the patient's talking, salient features should be noted and if necessary, questions asked then or better still later. The emotional reactions should be particularly noted, so that if the patient complains of or shows depression for instance, questions can be asked to elicit if there is a sense of hopelessness, retardation, ideas of unworthiness, or in other words the classical points indicating primary depression.

Having got the patient's account of the present trouble, ask for the background, whether the parents were highly strung or nervous, the number of brothers or sisters, whether they were nervous, suffered from depression or showed any such traits. The position of the patient in the family can then be asked and if he had a healthy and happy childhood, whether he was nervous, afraid of the dark, shy or easily embarrassed. He should be asked if he was naturally reserved, or a good mixer of the 'hail fellow, well met' type, if he has a vivid imagination and is a day-dreamer, or if he experienced mood swings. If there are any obsessional features, find out if he is naturally exact, tidy, methodical and with a pigeon-holing mind. By this time the physician will have a picture of heredity factors, of the patient's previous personality, previous illnesses, and of the present situation. With this information he will be in a position to decide upon the line of treatment that it is wise to adopt, and to go straight ahead with analysis if it is indicated.

The preliminaries having been completed and analysis finally decided upon, it is usual to give some sort of an explanation to the patient of the procedure. It is wise to explain that there is a conscious as well as a subconscious part of the mind, also that there is a close connection between the autonomic nervous system (detailing simply its

functions) and our emotional life. This procedure will enable one to explain how emotional reactions such as fear will show themselves in physical forms, like palpitations of the heart. The simpler such explanations are, the better. For instance, the patient can be reminded how he will feel his heart beating if he is crossing the road and sees a motor car bearing down on him, so that it makes him leap to the pavement for safety ; as the saying is, ' his heart is in his mouth ' and it can be pointed out that this is not due just to the leap to the pavement but is due to the fear.

Then the basis of free association starting from the association of ideas, thoughts and experiences must be explained, finishing with a description of the difference between directed, critical thought and free association.

The next step is probably best carried out with the patient sitting in a comfortable armchair, although some analysts prefer him to lie on a coach from the beginning. He is encouraged to talk completely freely about his difficulties, his worries, or his life as a whole, just as the thoughts come into his mind. He must be warned not to criticize his thoughts, but to speak them aloud. Sometimes a patient may be speaking of his parents and stop, saying that he is being disloyal to them. This can be explained to him, so that he realizes that it is all part of the treatment, and he is not being disloyal. The author usually says that

the patient must realize that the old idea that a child loves and respects his parents just because they are his parents, is all wrong. How can one respect a drunken father, or an immoral mother, or love a parent who has shown little or no affection. A child should love his parents just because those parents give him that amount of unselfish love and affection which draws back his love to them. Then also, as the child reaches adult life he can realize the faults and mistakes of his parents, without losing his respect or love for them. In any case, the analyst is primarily interested in his patient's health, not in the parents, and what the patient is recounting about his parents is of no consequence to the analyst except so far as it helps him to get his patient well.

If the patient does not seem able to talk freely, it is permissible to set his thoughts in train by a series of questions, or by guiding him into some particular line of thought, such as his childhood, his old home, the games he used to play. It is important not to suggest any actual conception into the mind of the patient.

As the analysis proceeds several difficulties may arise. The patient may ' dry up,' and be unable to talk his thoughts aloud. This may be due to embarrassment. This difficulty arises either from the fact that he has been unaccustomed to talk freely and openly to anyone, or to what is termed a ' resistance.' A resistance is encountered when some experience is

passing from the subconscious mind into the memory of consciousness, but the memory is too painful for the person to relate and admit to himself.

One technique in these circumstances is to allow the patient an adequate period of silence in order to see if any memory is produced, and then, particularly if obvious embarrassment is creeping in, to ask some further question, so turning his thoughts into another channel. The analyst should note the chain of thought which led up to the period of silence in case there is some signficance about the silence, and subsequently try to get to the core by another chain of associations. If the analyst is fairly certain what is causing the resistance he may enable the patient to overcome it by giving illustrations to the patient of similar situations. For example, a female patient may come to a dead stop over what the analyst may feel certain was masturbation in her childhood. The analyst may get round the difficulty by giving examples of difficulties that he has known girls to have, casually mentioning masturbation as a common one. The patient, who possibly has been believing it a crime peculiar to her, will, on realizing that it is a not uncommon condition, often overcome the resistance and speak freely about it. At other times the resistance has got to be left alone, other associations being followed until the old one comes up again and is overcome.

One of the main objects of an analysis is to enable the patient to have an abreaction. During an abreaction much emotional reaction is displayed over the recounting of some experience, and the patient lives again the original emotion attached to that experience which has been repressed. A good example of abreaction was shown in a patient, a hard-headed business man, who, to his intense disgust and annoyance had started to develop anxiety symptoms and dislike of going in trains. He had been talking freely about various topics when association led to his father, whereupon he burst into loud sobs, finally going on to give an account of much psychological upset in this connection. The patient must be allowed to work off his emotional reaction to the fullest possible extent. At the same time control of the situation must be kept by the analyst, otherwise the reaction may be too violent or too long continued. Occasionally under very heavy emotional reaction the patient may try to find further oblivion in drink or drugs. It may be very difficult to keep control and yet set up no further psychological difficulties.

Probably less stress is laid on the transference situation by this school of thought than by the Freudian, though the importance of transference must not be under-estimated. At the same time explanation of the transference situation should probably be given earlier and more readily by the analyst, especially if

he feels that the situation can be grasped intellectually by the patient, rather than waiting for the patient to resolve it himself. In this way more control of the transference is kept. Sometimes a 'negative' transference may become so strong that the patient will break off the analysis. It may be wise to leave well alone at this point, knowing that the patient will gain insight and come back. Should the patient not come back, or write, after a reasonable time it is quite justifiable to make contact with him in such a way as to soothe him down sufficiently to start again and so learn the reasons for his action. On the other hand, it is more common and perhaps a safer technique to placate the patient sufficiently to avoid his going off, and then explain the transference situation to him. Similarly a positive transference must not be allowed to develop in such a way as to make the patient dependent on the analyst and the patient be unable to resolve it. In this technique the physician keeps a greater degree of control than does the Freudian. More time is given to solving practical problems and environmental difficulties, and the physician is more inclined to rest content with the improvement that can be wrought by, say, a three- or six-months analysis. In this way the physician helps a patient to see the position for himself rather than working back all the time to any fundamental factors in infancy. It is often extremely hard to know when to help a

patient to understand the significance of his behaviour of some mental mechanism, dream or material produced during free association. It is always essential to avoid suggesting ideas to a patient. It is also a common experience that the acceptance of some truth does not relieve the patient of his symptoms unless in realizing that truth he has worked off the emotional reaction, which was attached to the experience under discussion. The ideal is to attempt to analyse so that the patient himself comes to a realization of the true position. Sometimes he can be helped to do this by giving a parallel illustration. For instance, if a man has brought out much material which shows clearly that he has always been tied to his mother's apron strings, and has never made his own decisions, or stood on his feet, and yet does not see the significance of this, it may be possible to help him to realize it by describing a similar hypothetical case, and asking him what he feels about such a patient as you have described to him.

If time is not a great consideration, the patient is gaining insight into his mental mechanisms and is working off his emotional reactions ; allow him to see the situation for himself. If his intellect is not very good, it is often better to explain the truth to him if it is more or less staring him in the face, and yet he cannot see it. If there is a big emotional factor involved which is not being released, do not force him

to see the situation by explaining it to him, or else there may be too big a revulsion. For instance, if one has a paranoid patient who is on the border of forming a delusional system and who, from his dreams and general reaction, gives the analyst the impression that he is essentially a homosexual, although it has never even barely reached consciousness, it may be both harmful and dangerous to explain to that patient that his real trouble is homosexuality, showing him the reasons for your conclusions. Again, if a patient has a strong religious basis to his character, it may be really bad practice to try to remove it, even though the analyst may feel that to some extent it is being used as a defence.

Attention must be paid to the phantasy life, and dreams of the patient, and each dream should be analysed if possible. The analysis of a dream consists in working through the content of the dream as recalled by the patient. Free association on each item or incident being carried out in order to elucidate the 'latent content' which is the hidden or real meaning of the dream. In doing this, symbolic manifestations, dramatizations of persons or experiences and identification may become clear, and lead the patient to the true understanding of some problem which previously had been repressed, and in the unconscious. Many dreams stand for wish fulfilment, such as the typical explorer's dream which is common

in time of hardship after the explorer has been away in the wilds for a long time. The dream is usually of warmth, comfort and luxury, bright light and company at home. Many dreams with a sexual basis are unconscious wishes. Some dreams typify anxiety states, such may be falling or climbing dreams. It is always worth while asking what emotional reaction is usually associated with the dreams. The phantasy life of a patient is often revealed during an analysis, and may prove to be a useful source of information, though it is important to be able to separate phantasy from real experience, which is not always easy. In analysis, phantasy may show, as can the dreams, the trend of the patient's thoughts when not under the criticism of the Super-Ego.

On beginning analysis a Freudian lets the patient relate exactly what he has in his mind, and he does not take a medical history or insist on a complete physical examination. If it is thought that a physical examination is necessary, and one has not been made before the patient came to the analyst, he is sent to someone else to have this done.

As soon as possible the patient is made to follow out the method of free association. Sometimes a certain amount of explanation about the procedure and what is meant by analysis is given. The patient is made to lie on a couch, the analyst being placed behind and not in the direct vision of the patient, and

the patient is told to speak his thoughts aloud, telling everything that passes through his mind and keeping back nothing, however irrelevant, immaterial or disgusting the material may seem to be. The patient has four or five sessions a week, each lasting about fifty minutes, and the year is divided into three terms.

During the analytical sessions the analyst usually gives the patient no guide as to the particular line of thought he is to follow, nor, if there is a long silence, does the analyst attempt to bridge it, but he may allow the patient to go through most of, or possibly all, the session in silence, hoping that the silence, which may be a 'resistance' will be overcome, and that some mental association will bring into consciousness repressed unconscious material.

A Freudian insists that his patient works out and sees for himself each psychological situation, making no attempt to explain the situation or get an intellectual understanding of it, at any rate until all the emotional content associated with it has been released and worked off. The emotional discharge and working off of the emotional tension is an extremely important part of the Freudian technique. In the same way the 'transference' that develops between patient and analyst is allowed to resolve itself, although there are Freudian analysts who make use of the transference to explain its significance to the patient. For example, if the patient is developing a

strong 'negative transference' towards a repressed 'oedipus situation,' it may be obvious to the analyst that he is for the moment a father substitute (or image), but he makes no attempt to ease the situation or improve the transference, rather allowing the patient to solve the situation himself. By an 'oedipus situation' is meant that the patient has had too great a sexual attachment to his mother, which he has repressed so that it has become unconscious and because of this he has felt jealous of, and antagonistic towards his father. This feeling towards his father is also very probably repressed, but is always trying to rise to the surface and come into consciousness. This may be shown consciously in many forms; the patient may never get on well with his parent, or may be afraid of him. During the analysis the repressed material begins to come into consciousness, the old emotional reaction is again associated with it, and is projected on to the analyst in this phase, hence the patient resents the analyst's very presence, may be rude, indifferent, or actively hostile to him, until the patient comes to realize (if the analysis proceeds satisfactorily) that the person he is really hating is not the analyst, but his father. Then when he gets a step further in the analysis he realizes that he hated his father because his father had more of the love and companionship of his mother than he himself had. When this further realization is appreciated, obviously

there is then no reason for hating the analyst, and so the negative transference is resolved back to its normal degree. At the end of a session, or periodically, the analyst explains points to the patient, or impresses them upon him.

In the Freudian technique less attention is paid to what might be termed the practical difficulties of controlling the analysis. Even if the patient begins to show signs of rebellion, sleeplessness or other indications that he is finding it difficult to face up to a 'reality situation.' So far as is possible he is urged to work out the puzzle through the analysis alone, rather than be helped by other aids, such as medicine. Less stress is laid on any practical problem with which the patient is faced, or any psychological upsets which have occurred comparatively recently, say in adult life, the aim always being to get back to the earliest years and the situations created between parent and child.

In Freudian technique much more attention is paid to such fundamental conceptions as the 'oedipus and electra complexes' or 'castration' fears. The very early feeling of frustration, of being deprived of the breast when a child with its close association to aggression is another important fact. The importance of fixation of sexual development at the anal-erotic stage is stressed by the Freudians as a frequent cause of symptoms needing deep analysis. The

Freudian concept of dreams is that they always stand for wish fulfilment, the buried wish being in the sexual life of the patient, usually genital or pre-genital. The Freudian analysis of dreams, therefore, goes rather deeper, and makes more use of symbolism. It can easily be understood that an analysis going as deep as this may well last for many years.

The technique of the Jungian school of thought differs chiefly in its application of psychological principles to the problem of the patient.[1] The preliminary history-taking and physical examination are followed by the patient being put in a comfortable chair or on a couch, and made to recall and recount his thoughts by the process of free association, in much the same way as has already been described, more contact being kept with the patient than in the Freudian technique.

The Jungian takes more into consideration the Collective Unconscious, that is to say the total results that have built up an individual's unconscious, from years of inherited ancestry and evolution. A great deal of information of this Collective Unconscious has been gained from mythology, and perhaps the Jungians more than any other school tend to link up psychology with religion. Jung, himself, makes use of the definite hypothesis that there is a demonological entity in the life of every one of us, which

[1] See Bibliography.

should be balanced by the 'God' dominant. He does not hesitate to help the patient to see that sometimes his reactions to life may be regarded in the light of motivation from the Devil, and that this must be dealt with in some way, probably by the antidote of God and His principles. In using the term God it must be understood that the Jungian conception of God is not the orthodox view.

In order to help the patient to get a clear understanding of his unconscious motives and mechanisms, the Jungian makes very free use of dream analysis and the phantasy life of the patient, correlating it so far as possible with mythology and symbolic life. Jungian analysis is, therefore, particularly applicable to the rather shut-in, introverted type, who has a rich phantasy life, or to the mystic who may be 'psychic' or mediumistic. A lot of such types are most closely related to the schizophrenic group. The Jungian will get such an individual to recount his dreams, will then help him to understand the meaning of those dreams and explain them to him as the indication of his true self and real life. The analyst will contrast this with the actual behaviour of the patient to life, indicating to him the harmful results of the latter and so will bring him to the point of making an adaptation to his real inner life which formerly had lain hidden in the unconscious.

Adler stressed the importance of a sense of

inferiority showing that this can begin at a very early age from 'organic inferiority' such as a poor skeletal development, or some endocrine dyscrasia which makes life more difficult for the individual, and he correlates this with our Will to Power or the effort of each one of us to succeed.[1]

The Adlerian, therefore, gets back to infantile memories, and attempts to show how early behaviour problems produced some sort of psychological stress and upset. For instance, a common question to ask a patient is 'What is your very first memory?' An attempt is then made to show the patient how a different reaction to the problem would have obtained a result free from conflict, with no loss of personal prestige, and yet in harmony with the dictates of the herd.

The Adlerian pays a good deal of attention to helping the patient get over his practical and environmental difficulties. The technique aims rather at getting to grips more quickly with the dominant problems and solving them in such a way as to bring relief and insight to the patient.

In addition to what one might term the general method of analysis by free association, there are several adjuncts which are helpful in difficult cases, though their usage varies considerably.

During the War, hypnosis was used in conjunction

[1] See Bibliography.

with analysis. If for some reason the analysis could not be proceeded with, the patient was hypnotized, and then suggestions were made that he could recall certain events and speak about them, and he was urged to speak freely while under the influence of hypnosis. In some cases it was possible to take him back step by step to some experience under the influence of hypnosis, and allow him to 'abreact' the whole experience. In civil life, where the psychological difficulties probably go right back to childhood, and may be concerned in environmental upset as well, hypnotism is not such a useful aid to analysis as in war time when the trauma may be dramatically severe, but of comparatively recent origin.

On the other hand, in some cases of 'conversion hysteria' in which the chief symptom is aphonia, amnesia, or a paresis which prevents the patient from walking, hypnotism may be the best way to start treatment, so that when the patient is able to talk or walk to the physician analysis can be commenced.

What has been termed Narco-analysis has recently been utilized with varying success. The technique consists in giving the patient a sufficient dose of some hypnotic to render him drowsy without loss of consciousness, the rationale being that his inhibitions are released and he talks more openly and readily under the drug. Nembutal has been used for this purpose. It is sometimes useful in patients who have

a strong resistance or seem unable to bring up any conscious material.

What is about to be done is explained to the patient who is put to bed in a state of complete relaxation. Nembutal is then injected intravenously very slowly about 1 c.c. every minute until the patient is just drowsy and losing consciousness, but able to talk. The Nembutal is then stopped and the analyst stays with the patient either listening, or prompting with questions. Amyl hydrate is also being used most effectively for this purpose with some patients.

One of the earlier aids to free association was the 'word association test.' This is at times used in modified forms.

The old method was to read out to the patient a carefully selected list of words, telling him that as the physician says any one word he must immediately answer with the first word that comes into his mind. The reaction time between the test word and the answer is noted, and whether the patient shows any emotional reaction with his answer. The average reaction time is about 1·5 seconds and the association between test word and answer should be obvious. If there is a delayed reaction time, an unusual association, or any emotion displayed, it may indicate that a subconscious strata has been tapped and so a clue obtained. Another method is suddenly to ask the patient when off his guard to say the first word that

comes into his mind, the main object being in such efforts to start the free association going in the right channel.

With patients who make great use of phantasy, particularly if they are of dissociated type, it may be possible to gain a clue by automatic writing. The patient is given a pad of writing paper and a pencil, he is placed in a comfortable position and allowed to sink into a dreamy, drowsy state. Occasionally drawings or actual writings will prove of importance. The choice of treatment and the type of patient suitable for analytical technique is considered in Chapter VII. This chapter will be concluded by giving two examples of cases chosen for short analytical therapy.

If, in the first few interviews, it is obvious that the personality traits are good, and that the symptoms seem to have developed in association with some external environmental difficulty, it is perfectly justifiable and good therapy to carry out an analysis sufficiently deep to show the patient how his present symptoms have arisen, and to help him to adjust the external problem. The Freudian school of thought might criticize this on the ground that unless the analysis was deep enough to get down to and elucidate the infantile situations the patient is only helped temporarily, is not really cured, and so will relapse at a later date. I think practical experience has

shown, however, that this is not necessarily correct; also that sometimes after a full Freudian analysis a relapse with return of symptoms does at times occur.

A girl aged 18 was referred by a surgeon to the psychological department for anæsthesia around the knee. The anæsthesia followed a slight injury, and now, many months after the accident, the knee was still letting her down. The following essential points were elicited:—

(1) She had a good personality history.
(2) All question of compensation was finished, and the firm had treated her well.
(3) She did not like her work.
(4) She had always wanted to be a children's nurse.
(5) All arrangements had been made for her to go to a College for training as a children's nurse, when at the last minute it had been cancelled.
(6) It had been cancelled because her younger sister (there were just the two of them in the family) had been very anxious to continue her music and stay on at school to do so. In order to keep their younger daughter on at school for this purpose, the parents had made their elder daughter give up her training.

The second case was also a girl of about 20 who developed suddenly a severe torticollis. She also had a good personality history, had done well at school

and in early life. The points that came out on superficial analysis were:—

(1) She lived with her parents in a small village, the populace of which were almost all employed in a local factory.
(2) Her father and relatives worked in this factory.
(3) She had always hated the idea of working in this factory, and had promised herself that she would not do so.
(4) After leaving school, however, she had been put into the factory and was very unhappy there.

In both these cases one cannot deny that some psychological upset in infancy may have predisposed them to break down in adolescence under a strain which would not have proved too much for another individual. Even so, the practical result, which is after all what the patient wants, was sufficiently good in these two cases to justify a superficial analysis without going too deep.

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CHAPTER III

SUGGESTION AND PERSUASION

Perhaps the oldest form of psychotherapy is suggestion. It has been a weapon in the hands of physicians from time immemorial. The bedside manner of the physician owes its value to the power of suggestion, and everyone would admit that the personality of a physician, the way he deals with a patient and prescribes treatment is of infinite importance, an importance which is based on the power of suggestion.

The fundamental principles of suggestion are still not clear. McDougall postulates an innate passive sympathy which is shown particularly in herds when the cry of one animal whether it is the cry of fear, anger or of the chase, will stimulate in animals of the same species a similar emotional reaction which will bring into action the instinctive urge or action with which this emotion is linked. Primitive passive sympathy may link itself to the self-submissive instinct when an individual will be prone to accept some proposition, even in the absence of rational belief, and it is this blind acceptance which constitutes suggestibility. It is recognized what a

powerful part suggestibility plays in the production of symptoms, especially in hysterics, normal children and those who have not got a highly developed sense of logical reasoning. If a child falls and cuts its knee slightly, and those around by their anxiety, sympathy and remarks suggest (even without meaning to) that the cut is a bad and painful one, that child is likely to start crying, perhaps limping, and so behaving as if the cut was indeed a bad and painful one. But if that child had been alone, or those around had treated the situation with wise, but not overdone sympathy, the child would almost certainly have cried hardly at all, and would have taken but scant notice of the damage. This suggestibility, which there is in a varying degree in us all, can be turned to great use in treatment by suggestion, the patient being made to accept the positive idea of recovery, improvement or cure.

Suggestion becomes more specific in its therapeutic usage when it is used along definite lines or in its most intensive form of hypnotism. It is important to know what type of case it is legitimate to treat by suggestion. Those neurotics who are not suitable for analysis by reason of their age, lack of intelligence or chronicity, and also many psychotics, can all be helped by suggestion. Hysterics especially may respond to suggestion as already pointed out. When it is realized how com-

paratively few medicines are specific in their action, it can be appreciated how widespread is the use and power of suggestion. Suggestion in its more general form is constantly used in the effort to stimulate hope in a primary depressive. It is good therapy constantly to reiterate that in spite of the ideas of unworthiness and feeling of hopelessness, he is going to get well. Some of the earlier schizophrenics, and even the less acute toxic infective psychoses, need constant reassurance concerning their symptoms and the certainty of their recovery, and this again is all suggestion therapy.

Suggestion in the form of hypnosis can at times be most helpfully combined with medicinal treatment in old cases of encephalitis lethargica. Many post-encephalitics seem to be very suggestible and respond most satisfactorily to hypnosis. There are a certain number of patients whose symptoms seem to continue almost in the manner of a conditioned reflex, and in whom, even with analysis, no unconscious mechanism can be elicited. These patients may be able to break through the old circle with the help of hypnosis. For instance, a woman of over thirty had jumped in her sleep every night for about fourteen years. The jumping had been so excessive as to disturb others and render herself unfit for work. Investigation showed that she had lived all her young life near a munitions factory, and in the path of all the raids

during the war. Further analysis failed to reveal any unconscious material of importance. She was accordingly hypnotized and the suggestion of a restful night constantly made. Now after many sessions of hypnosis she is nearly well. It is always worth while to try the effect of hypnosis in stubborn cases of nocturnal enuresis, using at the same time, whatever medication seems best. In fact, positive suggestion has its value in almost every case, except one in which an attempt is being made to analyse out a particular psychological difficulty.

Suggestion should be given in a positive form with as much force of personality and certainty as can be brought to bear. All effusive reiteration which might be taken by the patient to be insincere or humbug must be excluded. The elderly hysteric who has a strong narcissistic element running through her, and who does not want to face up to the difficult realities of life, can be treated by suggestion. A careful, even elaborate, physical examination must be made, and followed up by some simple explanation of the psychological causation of physical symptoms, and then a strong assertion is made that the symptoms are going to disappear as a result of some new treatment which must be carefully thought out and administered. To sustain and increase the suggestion many other forms of treatment can be combined with verbal suggestion. For instance, massage may be

invaluable. A masseuse who has had some training in psychological methods is a great asset, particularly if she has a sympathetic yet dynamic personality which she can use for the purpose of positive suggestion. For instance, on one occasion a rather garrulous elderly man with an intellect below the average, was complaining bitterly of pain in his back and legs, following a fall from a haystack. No organic causes for this pain could be found, and nothing had seemed to do it any good, so treatment by suggestion was decided upon. A physician who had only seen the patient once or twice made a very careful and elaborate examination and then explained that he had really got to the root of the trouble, and found out what was the matter. He went on to explain that the trouble was deep in against the inner part of the spine and that the reason why all previous treatments had failed was that the applications were superficial and did not reach deep enough ; the only method he went on to say, which would reach the trouble was an electrical one in which the current would pass through to the spine. Having prepared the ground in this way the patient was stripped, made to lie on his face and a high frequency vibrator was run up and down his back until he almost begged for mercy. The whole treatment must, of course, be given in a really convincing manner.

It may be thought by some that such a method of

treatment is so unscientific as to be outside the propriety of a medical man's work. On the other hand the first aim and object of a doctor is to cure his patient, and while I suppose all of us would rather have a specific method of cure, if we cannot, surely we are justified in using suggestion, particularly if it is going to cure the patient as it did in the case just quoted. In any case, how often we give medicines on a purely empirical basis. It is only that the extra personal dramatization which is so essential to successful suggestive therapy gives the impression of chicanery and distresses some of the more orthodox members of the profession.

Hydrotherapy is often used beneficially in connection with treatment by suggestion. While not denying the specific benefit of certain baths for particular illnesses, I think that it must be admitted that in psychological medicine a number of baths act more by virtue of suggestion than anything else. In fact any method of treatment can justifiably be brought into action to aid and abet suggestion. A haphazard type of suggestion should be avoided and a careful routine worked out, so as to obtain the maximum effect from all angles.

In hospitals or nursing homes especially those devoted entirely to psychological work, suggestion can be a powerful weapon in the wards if used with a little ingenuity. A patient who is recovering, and

has gained insight and stability may be taken into the confidence of the medical staff, and put on to a new patient to whom a few carefully worded remarks about the recovery rate, the methods of treatment or thoroughness of the hospital staff may make all the difference. Working on these lines it is possible to get *esprit de corps* amongst a ward of patients which gathers an increasing volume of positive suggestion and like a snowball will increase as it goes along. It is possible sometimes in out-patients to arrange matters so that waiting patients get an apparently unrehearsed evidence of cure. On one occasion a girl was wheeled through a crowd of waiting patients into the physician's room. While in the room she was hypnotized and was helped sufficiently to hobble out with some support. The next week the same group of patients saw the same girl walk out stiffly but unaided, and the third week walk out normally. Such evidence carries great weight in the eyes of the other patients and can do nothing but good.

It is worth bearing in mind that often the person who is in the best position to treat by suggestion is the general practitioner or physician who first sees the patient, as he is in a position to create the right atmosphere from the beginning. The patient who has been seeing a number of doctors, who may have been told that his trouble is probably anaemia or

rheumatism or nervous exhaustion, and who then is referred to the psychologist, is so filled with ideas that have been suggested to him that it is impossible to produce the right atmosphere for suggestion. Hence the importance of knowing the type of person to treat by suggestion is obvious. It is also important to realize how easy it is to implant wrong ideas into the mind of a suggestible person. The number of patients who have been told that they were a little anaemic, without a blood count or haemoglobin estimation being done, must be legion. It is amazing how some patients will refer to that fact and harp on it. One appreciates into what an awkward position a practitioner may be put when an insistent patient demands to know what is wrong and nothing much can be found, but care should be taken to avoid making a suggestion which will perhaps make the cure of that patient more difficult.

Hypnosis is most useful in cases of acute hysteria, such as the sudden onset of aphonia, amnesia or paresis. With the poorer classes particularly it is not infrequently necessary to produce a quick cure so that the individual may get back to work to continue earning his living. Where this is the case it is perfectly justifiable and good therapy to remove the disabling symptom by hypnosis, and then arrange for a continuation of treatment by analysis, in order to try and find out the root of the trouble.

The main disappointment about suggestion as a method of treatment is that the patients tend to relapse, as the root of the trouble has not really been found and dealt with. It is, therefore, advisable, in any case which is suitable, not to rest content with a cure by suggestion, but to go on with analytical therapy and investigate the reason for the symptom having developed.

The technique of hypnotic suggestion varies a good deal. Ideally one should look for a subject who is reasonably intelligent, not of the suspicious, critical paranoid temperament, and who is not filled with fears or anxiety about what the treatment is. The patient should be told that hypnotism is used as a medical treatment, and that it has got beyond the idea of the showman's mesmerism. They are told that all they have to do is to try to have confidence in, and trust, the physician, who by employing this especial technique will attempt to get into such *rapport* with them as to allow a very special force of suggestion to sink deep into their mind, and so influence them in everyday life in such a manner that they will derive benefit from it. The power of ordinary suggestion can be emphasized, and they can be assured that ill effects simply do not exist.

Having explained the position to the patient he is asked to lie down on a comfortable couch, and to relax as if he were going to sleep. He is told not to

attempt to think about anything especial, or of what the doctor is saying, but to allow his mind to wander on pleasant topics just as he would if he were trying to go to sleep. He is told that he will, in point of fact, hear all that the doctor says, and that these words will sink into and impress themselves on his mind, and that he will pass into a dreamy sleep-like trance. He is then told to look at a bright object, such as the top of a silver pencil, held above his eyes and slightly behind, so that the eyeballs have to be turned up and back. He is told to keep gazing at this object until his eyes grow heavy and tired, that it is going to be more and more of an effort to keep them open, and that soon he will not be able to keep them open however hard he tries. Then repeat: 'They are closing, they are closing, they are closing,' and if necessary, the more positive command 'Now shut your eyes.' As the eyelids close the hand holding the pencil can be placed on the forehead with the approving remark, 'That is good, now sleep more deeply.' More definite suggestions are made as to the patient sleeping more deeply, or going into a deeper trance-like state until he is lying quietly with eyes shut and restful. A change in the respiratory rhythm, which should become deeper and a little slower, is often an indication that the patient is hypnotized.

It is often not easy to tell if the patient is going under and if the suggestions about closing the eyes

should be continued. If the eyelids begin to droop and are then opened with an effort, only to droop again, or if the pupils are seen to be dilating and contracting, the patient is probably going off. If the eyelids are blinking a lot, it may be a method of the patient's to try and avoid going off and suggestions should be increased. If, with the closing of the eyes, the respiratory rhythm lengthens and deepens, and the patient relaxes further, sometimes almost as if he is snuggling down under the bedclothes, he is almost certainly hypnotized. Occasionally instead of the eyelids closing they remain open but the eyes develop a glassy stare. This usually indicates hypnotism, and the eyelids can usually be closed quite easily by touching them with the hand, and giving the command 'now close your eyes, and keep them closed.' If after a matter of a few minutes the patient does not show any signs of going under, and a feeling of embarrassment is developing, or if the patient starts to talk and says 'I'm not feeling a bit sleepy doctor,' or again if he begins to giggle, the physician should with as much composure and *savoir faire* as possible stop the attempt, saying to the patient something like this 'Well, I think that will be enough to-day. I often like to try a preliminary canter, so to speak, in order to accustom the patient to the procedure. It is a queer sensation, isn't it, and you know you were a bit nervous, and afraid really to relax and let yourself go, weren't you?'

Some authorities hypnotize an old patient in front of a new one prior to putting the new one under. Other authorities will carry out class hypnotism, a new patient being hypnotized in the company of several others all of whom go off fairly easily.

There are briefly three stages of hypnotism. The first, in which the patient is quietly in repose and in a dreamy state, yet perfectly aware of everything that is going on around him, and able at any moment to break through the hypnosis and discontinue treatment of his own volition. The second or katatonic stage is one in which the patient is still aware of what is going on around but is unable to move, open his eyes or discontinue treatment without the wish of the physician. In this stage, if the patient's arm is lifted up and left in that position without even a word, it will often remain poised in that position just as in the flexibilitas cerea seen in dementia praecox. The third, or somnambulistic state, is one in which the patient is even more deeply under the control of the physician, and has no knowledge of anything that is going on around and yet is perfectly aware of all the physician says without remembering the words spoken when being awakened.

It is often necessary to explain to the patient that he is definitely more suggestible than usual when in the first stage, and that good can be done to him in this stage, as unless they go into the third stage and

become unconscious of what is going on around they feel that they have not really been under.

It is difficult to foretell, and to control the stage into which a patient is going to pass. Sometimes by an increasing number of sessions, and by suggesting that next time they will go off more easily and go into a deeper phase, a greater degree of control can be obtained. Some patients go into, say, a deepish first stage, but can never be sent deeper.

When the patient is as deeply hypnotized as he can be at any particular session, positive suggestions on the specific point can be made. It is often best not to attempt anything too dramatic in the first session. For instance, in the patient previously mentioned who had a chronic fear reaction dating back to air raids and producing 'jumps' at night, the following suggestions were made: 'You are now lying quietly, peacefully at rest in the security of the hospital. When you go to bed to-night you will feel the same sense of security and peace, and will sleep restfully without fear.' The suggestions can be repeated six or a dozen times using a varying pitch of voice and earnestness, sometimes forcible, sometimes rhythmically monotonous. While the suggestions are being made it is helpful and impressive to lay a hand on the patient's head or arms, or if suggestions are being made about some particular part of the body, to handle that part of the body. If there is a paresis of

some limb, the limb itself can be moved and handled while the patient is under the influence of the hypnosis, and he can be instructed to move it. It is possible to get a paralysed limb moving quite freely while the patient is under the influence of hypnotism. The suggestion can then be made that the same ability to move will be present when the patient is awake from the hypnotism, and the patient can be brought round. Then quite naturally with perfect confidence the hypnotist should say to the patient, 'Well, what do you think of this?' and at the same time set the paralysed limb in motion by say, shaking hands, or making the patient walk. It is advisable to try not to look too surprised if the results are beyond expectation. In difficult cases the degree of improvement may quite probably not be dramatic after one treatment in which case the improvement, such as it is, should be pointed out to the patient with such a remark as 'Look, even after one short course of treatment there is an improvement, that shows we are on the right line now, just wait until next time' In some cases it is good technique to get the patient moving the limb while under the influence of hypnotism by carrying out some purposive action such as walking in the case of a paretic leg and then to bring him round while he is actually in motion with some remark as 'Now you will see for yourself'

After a few minutes to half an hour the patient can

be awakened. This is easily done by saying, 'I am now going to count five, and you will awake on the word five.' The physician then simply counts five, and it is often a good plan if it is doubtful whether the patient has really been hypnotized to count four quickly and then pause before saying five. If he is really off there will not be a flicker of an eyelid until the word five is pronounced.

The frequency of the actual hypnotic sessions can vary considerably; it is probably best to aim at intensive treatment and to start off with a session of about half an hour every day, gradually cutting it down. It is possible to do quite good work with as little as one session a week. It is probably best to discontinue treatment as quickly as one reasonably can lest the patient get too dependent. In most cases a course of a month or two is sufficient, with possible recurrent shorter courses.

Some authorities have included persuasion as a method applicable to psychotherapy. The term is used to denote that the patient is helped to accept some fact more by reason of his understanding why he should accept the fact, than by accepting it on no rational ground, but just because he is told to do so. It seems almost to be splitting hairs, as obviously the more you can make a fact appeal to the intelligence of a patient, the more likely is he to accept that fact with conviction. There are, however, patients with

whom one can argue and whom one can endeavour to persuade while there are others whom it is unwise to treat in this way. It only annoys and upsets a paranoia to try to argue with him and persuade him that his ideas are delusions and are symptoms of his illness. An attempt to persuade a paranoia that his delusions are incorrect may only lead to him turning his resentment and hostility on to oneself.

Similarly any attempt to persuade a melancholic that he can pull himself together and get out of his depression by his own unaided effort is bad therapy. There are many obsessionals and hysterics who can be persuaded to adopt a different attitude to their symptoms and to see some of them in the light of behaviour problems. For instance, a very severe obsessional who had for a long time felt confined to the hospital and not even able to go upstairs lest she should jump or throw herself out of a window, or off a balcony, was persuaded after a series of therapeutic interviews to go out of the front gate of the hospital and walk some twenty yards to the other gate by which she could go in, and up to the top of an empty house without much trouble.

CHAPTER IV

RE-EDUCATION

There are so many practical considerations which often have to be dealt with in psychological medicine, that it seems worth while to include a chapter on these items. There is the re-education that goes *pari passu* with analysis, and in addition social adaptation and environmental change.

It is abundantly clear that the process of civilization has got so far away from the more natural, instinctive life, and that so many mistakes have been made in this process of civilization, that constant conflicts are arising between the individual and the herd. These difficulties are practical problems which cannot necessarily be removed by analysis.

In the same way analysis is really a means of helping an individual to know himself in the fullest sense of the word, and obviously unless that individual is prepared to make use of his knowledge then he will not benefit from the analysis. As has already been pointed out if a person comes for treatment because of an anxiety state, and analysis shows that the anxiety is due to his inability to get on with his

colleagues at work because of his bad temper and tendency to project on to his colleagues, he still has to make the conscious effort of self-control to prevent his anger getting the better of him.

Moreover, although in analysis the endeavour is to relieve repression and unconscious conflicts so completely as to free all the emotions and rid the patient from symptoms, I fear that most of us would admit that only too often some sequelae are left over, and it is necessary to help the patient consciously to grapple with these difficulties. Take, for instance, a patient who has an obsessional anxiety about his own physical health. He may see through analysis that most of his anxiety is due to his own narcissism and the fact that his parents projected their fear about his health on to him, yet in some cases, under certain circumstances his anxiety will increase to fever point, and even a long analysis seems unable to free him sufficiently to make him symptom-free.

Again, with a severe hysteric, it is extremely hard at times to be sure to what extent he is playing up his physician or his nurse against someone else, and there are cases when that situation needs a direct attack and re-educative help rather than further analysis.

It is clear, therefore, that in many cases even after a prolonged analysis, whenever symptoms have not been completely removed it is necessary to continue

treatment along re-educative lines. Some of the obsessionals and psychopaths, who are resistant to analysis, as has been stated in Chapter I, are most helped by re-educative methods. If an individual realizes that his symptoms are by no means particular only to himself but are common to many, that there are people who regard them as an illness and to some extent understand them, it is extraordinary how much help and comfort he can get from this knowledge, and how he will welcome the re-educative talks.

Much re-education has to be carried out with the introverts who have shut themselves off from their fellow creatures. Most big clinics for psychological medicine have some means of opening up some social life for a patient. The psychiatric social worker is invaluable for this work. She should be in touch with various bodies who help to provide social life, and different means of enabling a patient to develop his hobbies or take up some new interests. A good occupational therapy centre is also of great service in this direction, and there should be close co-operation with such a place. Such movements as The Young Men's Christian Association, The Salvation Army, The Young Women's Christian Association, the Scouts, the Guides and different sports and athletic associations are all helpful.

A big problem these days is that so many children have to look after and help support their parents

when they are elderly. Patients are frequently seen who have never been able to open out and develop their own lives because all their earnings had to be used to support their parents. The moral obligation too, may make them feel that they ought not to marry or leave home, and when this coincides with their falling in love it is easy to imagine what a conflict arises. This is a problem that sometimes defies all effort of re-education and social adaptation. An attempt should be made to get the co-operation of the parents to show them how their child may become ill and so be a burden rather than help to them if he is not allowed to open out his life and to marry the girl that he loves. It must be explained to the young couple how necessary it is for them to have their own life even if they have to be particularly careful in order to help support their parents and they must be helped to realize that it is not just selfishness to want to marry. This may well bring up the question of whether they can afford to get married. Not infrequently a man with a fine character will feel that he ought not to marry unless he can completely support his wife, and he will abhor the idea of his wife working too, and so helping to support the home. It must be explained to him that the old idea that a man must entirely support his wife was based on ancient lore, that now man does not have to have the same protective quality, that women have become

much more on the level of companions and that a man and wife should share things together. It can be pointed out how much healthier and happier it is for a woman to have her married life, even if she has to work, than for her to remain in love and yet single. It should also be explained that often the unwillingness of the man to allow his wife to work is based on that old possessiveness that is so powerfully present in most men and yet so harmful if allowed to reach unreasonable proportions and that there may be a false pride making him think that other people criticize him for not supporting his wife completely. Then such a case often calls for instruction on contraception. There are, however, so many books on this subject and such good clinics that further reference will not be made to it here.

Having helped them straighten out their own opinions on the problem perhaps it may be possible to give them practical help, such as arranging for an elderly invalid and entirely dependent mother to be moved to some suitable and happy home.

The only child who has been kept too much at home, and never allowed to make decisions or stand on his own feet, may need much re-education to enable him to face the difficulties of the outside world without always wanting to rush back to his mother or a mother-substitute. Such a patient may also have never had the chance to open out his life along the

lines of his natural gifts, and much re-education can be done in this way. Again it is necessary to get the co-operation of the parents and tactfully to point out to them the necessity for their child to begin to develop his own life. Sometimes a start may be made simply with a good boarding school, or university life, living away from home. It is a good plan generally to find the patient's natural interests and to put him in touch with societies, clubs, or individuals with similar interests. Arrangements must also be made through individuals or clubs to give him a chance of making acquaintanceship with both sexes. From this beginning responsibilities and decisions can be forced upon him, and he must be encouraged to deal with them of his own accord.

This last problem leads naturally on to another very common situation that calls for social adaptation, namely, the person who is in unsuitable work. It is tragic to find how comparatively few people are in work which really interests them and which they really enjoy. Constantly it is necessary to find fresh work for a patient, or to try and find out for what work he is suitable. This is all due in part to the mistakes and failures of our present civilization, and it is at this point that psychotherapy must be thought of in association with the whole question of social evolution.

An advance which has been made in regard to

helping patients to find suitable work is that of vocational guidance. The Institute of Industrial Psychology[1] carries out an excellent series of tests which are calculated to show anyone's natural abilities. From these tests is drawn up a very helpful report, giving various suggestions as to the sort of profession or life-work for which the candidate is most suited. It is important from a prophylactic point of view to fit a person into the right type of work. In the examples given in Chapter II both the illnesses were precipitated by unsuitable work, and the analysis in each case was followed up by finding the right type of work for the two patients.

The present day economic situation, which renders it extremely difficult for people to get married young, and the social ethics regarding extra-marital coitus, has caused a great deal of conflict between the natural sexual instinct and the right policy to adopt. Moreover the large excess of women in the world means that a large number can never get married or live a normal sexual life, and thus a terrible amount of loneliness is enforced upon people. There has been far too great a tendency in the past for people to shut their eyes to these problems, just because they are so tragically difficult to solve. It is, of course, exceedingly difficult to suggest reforms without breaking up the family unit, which seems the most important of

[1] See Appendix.

all units, and also breaking away from the finest ideals.

It should be clearly realized, however, that when attempts are made to bring these problems into the daylight and to solve them, it is not just the sexual act which is under consideration, but the whole question of companionship and friendship, that unique companionship which can only come in the love of man to woman. Only those of us who have handled large numbers of out-patients can appreciate the devastating effects of loneliness and unhappiness that result from it. Much social adaptation is needed in this sphere, which is perhaps one of the most difficult with which to deal. Every psychologist has his own way of dealing with that extremely difficult problem that is so often brought to him of whether an adolescent should completely control his sexual feelings, should masturbate, or should have promiscuous intercourse, and again the problem of the two people deeply in love who for some reason can see no way of marrying for a considerable time. It is all very well for some people to say that chastity never hurt anyone, and that perfect self-control can be obtained, and is the only correct method, but they do not necessarily see for example, the students who, trying to fight their sexual feelings down, find that they cannot concentrate, get anxious about their work, and whether they will pass their examinations,

until insomnia supervenes and a vicious circle is commenced. Again the girl who is deeply in love with a man and is unable to see the chance of marriage in the near future, and who fears that she may lose his love altogether if she does not give him at least some of the love for which he asks, may start insomnia and an anxiety state or depression. It is possible to argue that individuals who are affected in this way are unstable, or of a poor calibre, but even if this is correct, which is doubtful, they still have to be helped and their lives straightened out. It would be well for moralists to bear in mind that many of the people who are not bringing up this problem and who are not suffering from any anxiety state have solved the problem by deciding to relieve their sexual instinct in one way or another. In considering these problems the physician must deal with each individual case on its merits. The author feels that the family unit, and that Christ's ideals are two of the most important principles in life, and that everything possible must be done to avoid breaking entirely from them. If analysis, sublimation, any form of psychotherapy, will remove the anxiety and mental strain from the young man there is no better method, but only in a few cases is this possible. In the majority of cases the whole problem should be talked out in detail with the patient, he should be given a full insight into the whole realm of sex as is described in Chapter V

and so everything possible be done to get rid of shame and guilt. It can be pointed out to him that occasional masturbation does no physical harm at all, and no psychological harm provided he has a clear understanding of why he is doing it, and can correlate it with his religious views if he has any. In contrast to the danger of promiscuous intercourse and possibility of contracting venereal disease, the fact that another person is being brought to, or encouraged to live a rotten type of life may be stressed and the selfishness of satisfying oneself possibly at the cost of someone else must be emphasized. The value of self-control, the relief that may be brought by sublimation, the help that can be had through Christianity must be given every prominence. The danger of breaking down ethics and codes of honour which the world is slowly and painfully trying to build up, must be pointed out.

Where it is a question of two people in love living together before marriage, the same procedure can be adopted but in addition the unhappiness that may be caused, particularly to the woman, if the partnership dissolves must be made clear. The unfairness and selfishness of bringing illegitimate children into the world and the importance to them of contraception if after every consideration they do decide to live together, must be explained. Finally, having discussed the problem from every angle, the author

usually tries to make it clear that in his view a maximum amount of self-control, Christ's principles and marriage, however difficult it may be, are the goals to work for, but that every individual must make his own choice and the physician cannot do more than make all the issues clear and put the pros and cons before the people concerned.

Lest there are some who feel that the above ideas are too unorthodox and are almost against Christ's teaching, it might be well to point out that the world seems to have got so far from its allotted course that measures which are not ideal may have to be used temporally in the attempt to get back. Surely there are few people to-day who would not wish for peace rather than war, and yet we must support a vast and terrible scheme for rearmament in order to help secure peace. There are also authorities who will not agree with the idea of bringing in Christ at all. They will make use of the arguments of the physiological state and social ethics, the individual's reaction to the herd and Freud's conception of the Ego ideal. Even so, in neglecting and even more in trying to break down the conception of Christ they are in the opinion of the author, using a two-edged sword.

There is much re-education to be carried out with regard to marriage. The problem of choosing the suitable partner, of happy relationships, and the best ways in which to maintain happiness, are all matters

with which the psychotherapist is concerned and with which he has to deal.

The illegitimate child and orphan present their own problems. They have more often than not been shockingly badly brought up and have much inferiority and sense of injustice. Finding them a suitable sympathetic environment in which to work, play and live, is all part of the work.

Another reform connected with children which is only just being dealt with, is to find how the parents who cannot afford to keep a nurse or maid can get some recreation in the evenings without leaving their children alone or else taking them with them. It is only necessary to go to a greyhound racing track to realize the harm done to infants by taking them there. Some crèches have been started to solve the problem during the day, but much more is needed. It may be possible to form a number of crèches where children can sleep during a night, or else form a panel of voluntary watchers who will visit and look after such homes for the evening.

The psychotherapist has not infrequently got to find a new environment for his patient. Sometimes a child's environment is so bad that it must be changed. The adult must at times be moved to a hostel or lodging from his home. It is not uncommon to find a family so hostile to one of its own particular members, that the life of that one is made a misery. For

instance, the life of an individual who is naturally artistic but is born of parents who have always expected him to go into one of the Services, may become impossible unless he is taken out of that environment and allowed to work in a sympathetic and uncritical atmosphere. Re-adjustment has often to be made between husband and wife. The husband out at work all day, comes home tired, wants to rest at home and read the paper, but forgets that the wife having been at home all day wants at least to talk if not to get a change of environment by going out to a cinema, or even for a walk. The husband who seeks his amusement at his club or with his new friends, always expecting his wife to find her own amusements, is worse. Many seem to forget how much it means to a woman to have in her married life the open love and affection, the little courtesies and romance which are usually there during engagement, but so often neglected afterwards. Thoughtlessness and selfishness, a failure or unreadiness to see the other's point of view, are all difficulties frequently arising, and it is often the doctor alone who can point out the need for re-adjustment. The wife whose control over her temper is poor, who fails to realize the fatigue of her husband on his return from work, who nags or keeps on asking him to do trivial things about the house when he wants to rest, who never thinks of making herself look nice, or of wearing a new frock just for

her husband alone, and who never shows any interest in her husband's work or profession except of a purely inquisitive kind, needs the importance of readjustment pointed out to her.

It may be seen, therefore, that a large part of psychotherapy can be concerned with work of the type described in this chapter, and this work, under the circumstances, can be considered just as much true medicine as pouring bottles of physic into people's stomachs.

CHAPTER V

THE EXPLANATION OF SOME COMMON PROBLEMS FOR THE PURPOSE OF TREATMENT

Anyone who is treating patients along psychological lines but who has not had the opportunity or time for an analysis himself, frequently finds it difficult to know just what approach to make. It is, of course, extremely hard to indicate on paper the right way in which to talk to a patient. No one would expect to become a good surgeon by reading how the operation is performed in a book. At the same time, it is helpful for an embryo surgeon to read, and so to get into his mind, the various steps which have to be undertaken in an operation. Perhaps the most helpful way of indicating this for the purpose of psychotherapy is to give as nearly as possible a verbatim account of conversations with patients, but the warning must be given that in talking to a patient the physician should use his own language and his own method of delivery, and not attempt to copy that of another, otherwise he will tend to lose his own personality which is of such importance. Moreover, the approach of one school of

thought may be totally different from that of another. It is hoped that this chapter may give a beginner some guidance until he can develop a technique of his own.

Some physicians find it difficult to explain to a patient that his illness is functional and in attempting to do so, give the patient the impression that they think that he is not really ill but malingering. Assuming that either the physician himself has made a full physical examination or else some other doctor has, and that any necessary investigations have been completed, then the following explanation can be given. 'You realize don't you that we have made a really careful examination of your body and have had certain laboratory investigations carried out, well I know you will be pleased to hear that there is no evidence of any organic or physical disease, that is to say, there is no growth, or ulcer, or inflammation, and we really can say, therefore, with confidence that this illness is due to an upset of your nervous system. You know people do not realize what a real illness and what queer physical symptoms can be caused by an illness of their nervous system; in fact, most of the symptoms from which a person suffers when ill such as palpitations, sickness, headache, and so on, can either be caused by a physical upset such as a growth, or by some big emotional nervous upset such as fear, worry or anxiety. It works in this way; there are

two parts of our nervous system. One which we call the voluntary part carries out any act we wish to perform, thus if I pick up this pencil and move it over there, a message goes from a part of my brain down the spinal cord, out by the nerves which control the muscles of my arm and hand, and so I make this movement. The other part of the nervous system is called the involuntary part. You realize don't you, that there are lots of activities going on in our body over which we have little or no control, such as the heart beat, or the movements of our intestines during digestion ? However much we try we cannot affect these movements very much by our will power. Now it so happens that that part of our nervous system controlling our involuntary movements is closely connected to that part of our nervous system which deals with our emotional reactions. This is the reason why fear may cause our heart to beat quickly, or why just before an examination or an embarrassing interview we may feel we want to pass water. It is in much the same way that worry, unhappiness and any form of mental stress may cause such symptoms as those from which you are suffering, and it is just as much an illness as pneumonia, or any other physical disease.' When the patient has been given such an explanation he may wonder whether it is not possible just to pull himself together, or whether the cure does not lie simply in

his, the patient's hands, as it is only nerves. The physician must explain that it is not possible for the patient to carry out the cure simply by himself, because some of the conflict causing the emotional upset lies in the unconscious part of the mind. This may necessitate another explanation, viz: 'Every one of us has not only a conscious part of our mind, but an unconscious as well. The conscious part is focused on whatever we are attempting to do, or whatever we are trying to think about at any particular moment. For instance, at the present time the focus of my consciousness is centred on explaining this to you. Even so I may be aware of something else going on, some noise or something. All of us have had the experience while our attention is set on something of hearing a clock strike and yet a few minutes later when we want to know the time we realize that though we heard the clock strike we were not sufficiently conscious of it to know what hour it struck. In other words the strike of the clock entered into consciousness, but not into the centre of focus of attention. Again we have all had the experience of seeing someone whose face was familiar and yet were not able to remember his name for a moment, but with a little effort we called it to mind. Here is an example of an experience having receded even a little further from consciousness. Finally, we have also all had the experience of meeting someone whose

face was familiar and yet no effort on our part enabled us to recall his name or the memory of where we met him. Then perhaps weeks later as we are passing say, a church, the picture of this man flashes into our mind and we remember that he was best man at a wedding in this church and the full memory comes back. While we were unable to recall this man's name or where we met him, that experience was in our unconscious and it is by a process of association such as the one described that we are able to get back experiences from the unconscious into consciousness.'

If a further explanation of the formation and genesis of the unconscious is required, an account of the instincts can be given as suggested in Chapter I.

Patients often ask why they have a sense of inferiority, and how it is possible to overcome it. The author commonly uses this explanation: 'Nearly every one of us has a sense of inferiority to some extent, because it goes right back to our primitive life. In primitive times the family unit was composed of the head male or old man who was surrounded by his group of females whom he jealously guarded by virtue of his strength. When a male child was born into that circle he was turned out as soon as his strength endangered the supremacy of the old man, and the young males were constantly trying to oust the old man, or to form a unit on their own, thus was engendered a sense of the father ruling by

might and strength, giving the male child a sense of inferiority. The human child nowadays being surrounded by its parents and nurses who seem to it so immeasurably bigger, stronger, more clever, and more able, naturally has a sense of inferiority compared to them. If by faulty upbringing this sense of inferiority is increased naturally it looms large in later life. For instance, if the father is a stern and strict man and rules by reason of fear, the child will have a greater sense of inferiority ; or if the child is much the youngest of the family and is conscious of being a little looked down upon by his brothers and sisters, again a sense of inferiority may be increased ; then there are the unconscious factors and physical defects which may increase inferiority. In order to cope with this condition it is necessary to find out by means of analysis the main features that may have increased what one may term the natural sense of inferiority. It is important for you to realize, however, that every one of us has this sense to some extent, and you must try to bolster up your ego by realizing that you are no longer the small child who is afraid of his father, but an individual with your own capabilities which can be used for the purpose of helping forward the scheme of life. Try to realize that some of the most self-assured persons have what is really a considerable degree of inferiority, but they are compensating or over-compensating for it. If you can

feel within yourself that you are attempting to lead the sort of life which helps forward the world as a whole, if you know that you are trying to make the life of your fellow creatures a little happier, brighter, and more jolly, in fact if you are trying to live your life according to high ideals and to do your job as well as you are able, then you can—in all humility—get that feeling of self-respect which will overpower your sense of inferiority.' The above explanation must, of course, be modified considerably according to the age, intelligence and social status of the patient.

A not-uncommon symptom with which one has to deal is what may be termed 'panic attacks.' These attacks vary from a straightforward anxiety attack to vaso-vagal attacks, and may include some of the phobias usually associated with the compulsive-obsessional neuroses or such conditions as fear of going out alone, fear of travelling in trains or fear of going into the Underground. It can be explained to the patient that these attacks are symptoms of the illness and will in many cases cease during the course of treatment as the patient gets better.

In the cure of the anxiety states it can be explained that they nearly always occur as a result of some association. For instance, one patient recalled that one of such attacks nearly always happened when she was out for her morning walk, and that it happened almost immediately after she had turned

homewards, and then she realized that waiting at home was one of the things she hated most, the drudgery of cooking the meals with the consequent washing-up. The fear of travelling, or going out, can be explained as a symbolic representation of some other fear which is in the unconscious, and then the patient can be asked to think of his fear in terms of symbolism and association and this will often provide the cue to a clearer insight. In some of the obsessionals even the explanation that the fear has no significance and is in no way dangerous, and that it is symbolic of something unknown, suffices to give them the ability to control that fear and live on top of it. If a person gets a panic-like state for no apparent reason he is very likely to be unable to control it, or he associates it with some physical disorder. If he realizes that it is a well recognized and known condition and that it symbolizes something in his unconscious, and is of no danger to him, then even if he is unable to analyse out what the panic symbolizes yet the knowledge which he has gained will help him.

Not infrequently a patient has to be given some sort of an education concerning the sexual instinct, and its ramifications. Most of the ground can be simply covered in this manner. 'So far as the question of education on sexual matters is concerned, parents can be divided roughly into three groups;

those who make no attempt to educate the child about sex and think that the child will find it out of his own accord ; those who feel it is their duty to tell the child something about the facts of life, and do so with so much awkwardness that they pass on that feeling of awkwardness and embarrassment to the child, and thirdly, those (unfortunately in a big minority) who have a clear conception of sex themselves and pass it on in a natural healthy happy manner to their children. It seems to me that the only way to look at sex is to realize that each of us is born with a certain number of instincts, i.e. a tendency to act in a particular way under particular circumstances without ever having been taught or shown how to do so (illustrate the nutritional instinct as Chapter I). We are not yet certain how many instincts there are but they are, broadly speaking, divided up into the reproductive instincts and the self-preservative instincts. Now whether one looks at it from a religious point of view or not, one cannot get away from the fact that the sexual instinct is inborn in us and perfectly natural to us, and if you believe in the creation by God, it is God-given, and therefore is not fundamentally wrong. So you see whichever way you look at it it is perfectly natural for each of us to have sexual feelings and there is nothing wrong in a man feeling drawn towards a woman and desirous of mating with her, or of a woman feeling

similarly towards a man, and we need not feel ashamed that we are like that. What we must learn to do is to control in the right and proper way our behaviour concerning these feelings. It is exactly similar to the fact that we cannot help feeling hunger, nor is there anything wrong in doing so, but we can control that hunger to the extent of not going to take food which does not belong to us, or choose the choicest food or more than our share. The reason why there is so much sense of shame and guilt connected with sex is that in the past we have thought far too much about the sexual act alone, and our failure to handle that situation with regard to our fellow creatures, and we have not thought of the importance of sex as a whole, that is, the companionship and contact between men and women, and all that the sexual urge gives rise to.

Roughly the sexual instinct develops in three phases: in very early life it is turned inwards and causes the child to have pleasure in its own body, to enjoy tickling and exposing itself. Then it passes through a phase at about eight years old when the emotional attachment is towards members of its own sex; this is the stage of the boy's hero worship and the girl's 'pashes' for her mistresses and other girls. Finally at puberty it reaches normal development when the attraction is to the opposite sex. It is extraordinary how often one finds the nicest possible

people ashamed of their own bodies, or embarrassed at contact with the opposite sex, and even inclined to think themselves nasty minded because they have feelings towards the opposite sex. If what I have said has been clear I hope it will be obvious to you that this is all natural and that there is nothing wrong in it.

In an explanation to a patient it is unnecessary at first to go into such details as the oral-erotic and anal-erotic states though such details may have to be made clear at a later date, during the course of a deep analysis.

There are all kinds of difficulties which may occur in connection with the question of sex, and it might be helpful to mention a few of these. Take the question of masturbation which occurs in both men and women. From what has been said it must be obvious that it is not unnatural for a child, partly as the result of curiosity, to stimulate itself perhaps by rubbing near the genital organs. The very young child has no thought of sex as the adult knows it and is not intending to do anything wrong or nasty, rather it can be regarded as a natural act, and the correct way to deal with it at a very early age is to avoid drawing the child's attention to it too much by any punishment or scolding, and to make his life sufficiently full of other activities to drain away his interest in other directions. The physician must

make certain that the physical condition is perfect, that there are no worms, or an over-tight prepuce. Keep the child healthily employed with its natural interests in play and exercise. In children from seven to puberty avoid giving any sense of guilt or shame and do not punish. In a perfectly friendly way find out what started the child masturbating, deal with any external causes, and then explain to him that it is one of the selfish acts of life as it gives him pleasure and no one else, also that it is a harmful thing to do as it is using organs which are not ready for use until he is older. Illustrate this by pointing out how it spoils a boy's batting at cricket if he tries to use too big a bat or tries to bowl too fast.

In older boys an explanation on these lines can be given. 'In the first instance do get out of your head the idea that you have been doing anything dreadfully wrong. I want you to get away from any feeling of secret guilt, shame and wickedness. Anything that you have read or heard about masturbation being the cause of all kinds of ill health and evil such as insanity, consumption or that it drains away your vital energies, is all nonsense and medically incorrect. Broadly speaking, masturbation does no physical harm at all, the harm it causes lies in the sense of shame and guilt which is usually associated with the act. Try to look at things this way. The sexual instinct is an absolutely natural God-given feeling,

and there is nothing wrong in having these feelings and desires.' (If necessary increase the boy's knowledge of sex as a whole along the lines previously described.) 'It is only right that you should realize that about your age the instinct comes to full development and when this is the case the natural and proper thing would be the full use of that instinct by mating with a girl. In these days, however, as a result of social economics it is almost impossible for young men and women to get married until they are twenty to thirty, and as you know it is the social code that men and women should not live together unless they are married. You see then don't you, that this big instinct comes to full development yet cannot be used to its fullest natural extent for some years, and so is it to be wondered at that people should have the desire to satisfy and get rid of the urge by masturbation? The great point for you to realize is that masturbation is an incomplete act, the sexual act is only full and completely satisfactory when it is with your life partner. Also it is obvious that self-control is an all-important factor in every part of life. You try to control greed, avarice, a bad temper or jealousy. In the same way learn to control the sexual desire and you will find that masturbation does not worry you often. Use your own common sense for working off the urge of the sexual instinct by playing games, taking up some creative work and healthily tiring

yourself out.' It is extraordinary how the desire to masturbate diminishes in intensity and frequency when once the act is divorced from any other emotional reaction such as guilt or anxiety.

Impotence may be an extremely easy condition to cure or alternatively may be very difficult. In many cases it is due to simple anxiety. The newly wed couple who have had no previous experience of sexual life and little or no helpful education are frequently a little embarrassed or clumsy, with the result that ejaculatio praecox occurs or the man's anxiety inhibits the total emotional reaction so much that the erection is not maintained. In cases of this type a simple explanation of the connection between the involuntary nervous system and emotional reaction can be given, pointing out how anxiety is related to fear and what a strong inhibitor fear is. In this way every effort should be made to restore the man's confidence and as much instruction as is necessary given about love making, love play and the easiest means of carrying out coitus. The woman should also be seen and her part made clear to her. So many men think that it is a sign of unmanliness to fail to consummate marriage. The couple, therefore, should be enlightened on this point. If, however, a simple explanation of the above type does not succeed, it usually means that the man has a bad mother fixation, has married a mother substitute, and so is

impotent as a result of the fundamental principle of sexual relationships embodied in the incest taboos. This is in the unconscious and only deep analysis is likely to cure it.

Frigidity is much more common in women than in men. It may be the result of ignorance and faulty education and can often be corrected by enlightening the woman on all that sex means, explaining to her how coitus should be a mutual act of adoration, joy and pleasure, not an occasion on which a woman is 'used' by a man, as so many women seem to think. Here again deeper psychological factors may be the real cause, in which case deep analysis is required.

One of the most difficult situations to handle may arise when a patient shows strong negative transference, resentment and antagonism towards the physician. This may be during analysis, or on the other hand it may be due to the suspicious antagonism of a paranoia. It may also occur with an hysteric who is trying to create a situation. Each position has to be handled slightly differently. It is absolutely essential that the physician remains calm, and has his own feelings absolutely under control, never allowing anything that is said or done to get under his skin. He should listen sympathetically to all that the patient says, but should keep his own emotional reaction quite detached. He must present an attitude of firmness and not allow the patient to feel that he

is bullying or browbeating him. It is useless to show any signs of impatience, to rail at the patient, or to give the impression of being bored with it all, and indifferent. The patient should be allowed to talk out what he has got to say, even if it takes a very considerable time. There is nothing more disarming to a patient than to feel that he has talked and talked and talked, and literally has nothing more that he can think of to say, and that all that time the physician has sat there quietly attentive, patient and interested. When the patient has literally dried up then the physician can begin to explain any points about which he has made a mental note, and for this purpose he should take points that admit of no argument; or alternatively he should quite definitely and firmly express his opinion as a medical man. He should take great care not to say anything that the patient can twist round or disprove.

The final step may come when the physician has to lay down the law to the patient. Again this must be done without any suggestion of anger, although it is permissible to allow an alteration of manner and tone of voice to indicate that the physician's mind is made up and that he is standing no nonsense. Tell the patient as simply and as straightforwardly as possible the facts, and, if necessary indicate that he, the patient, can have the choice of making a decision and so force him to take that step himself, instead of

making the decision for him. It is well to remember that an hysteric may attempt to manipulate the situation in such a way that the physician makes the decision, and so the patient can blame him for any difficulty or trouble that arises in future. As an instance, an hysteric who is showing a good deal of depression may, during analysis, create a situation by announcing that he is going to commit suicide and may do his utmost to force the physician to take some steps on account of this, such as moving him into a nursing home or hospital. So far as possible the physician must call the patient's bluff, if bluff it be, and force him to make any decision himself. This may be one of the most difficult and anxious positions in which a physician can find himself. If the patient's personality history shows any tendency to cyclothymia or there is a considerable degree of psychopathy in the patient or the patient's family, then the physician will be wise to play for safety.

CHAPTER VI

OCCUPATIONAL THERAPY

Occupational therapy[1] is one of the more recent advances of psychotherapy. Actually occupation has been made use of, particularly in mental hospitals for a great number of years, but usually in a somewhat haphazard way. In such places as the large mental hospitals where there are a great number of chronic patients, some sort of an employment has to be found. For those who are well enough there are the various shops in which they can work. These usually include the tailor's shop, the upholsterer's, the 'snob' or bootmaker's shop, and several others. In addition a number of patients work on the farm, in the fields and on the garden. Most of these workers are males, the women being chiefly employed in the laundry and sewing room. Amusement is provided with sports, dances and a cinema. Unfortunately, helpful as all this employment is, there has been little real organization in the past, and no controlling officer who is an expert in occupation. Moreover, little provision has been made for those patients who are too

[1] See Bibliography.

ill to do what may seem useful work, and it has been thought that to make such a patient work was more trouble than it was worth.

The modern conception of occupational therapy is that it should be applied not only in the treatment of people suffering from mental disorders, including under this term the neuroses, aments, and psychoses, but also in the treatment of all illnesses of long duration or with a tendency to chronicity. Occupational therapy has great possibilities in orthopædic work. Wherever it is possible to stimulate and interest the mind, to encourage co-ordination of mind and body and to help the art-loving creative side of an individual, helpful therapeutic work is being carried out. In this monograph we are mainly concerned with its application to psychological illness.

The organization of this therapeutic department must depend somewhat on the type of patient and the number for which arrangements have to be made. In a hospital where only the neuroses or milder psychoses are taken, the ideal is to have what might be termed an occupational bungalow, although excellent work can be done in a number of rooms especially set aside.

The best type of lay-out for an occupational bungalow would include a large hall or room for social activities, a craftsroom for men and another for women, a room set rather apart for noisy crafts

such as carpentry, and perhaps a domestic science room where cooking can be undertaken. If the bungalow is going to be used for more acute cases, then obviously separate rooms must be provided, so that they can work in safety to themselves and those around them, and not disturb other patients who are less ill than themselves. The rooms should be simple, adequately provided with cupboard room and well lighted. The majority of the space should be occupied by the different tools used in the actual craft work. If the position of the bungalow can be such that immediately in front a tennis court can be laid out there should also be a verandah added so that in the summer the patients can sit out in the fresh air watching the games and so forming a really useful social life. At the same time adequate arrangement must be made for giving the patients in bed, or in the ward, occupational therapy. This will largely depend on organizing the work in such a way that the occupational therapist gives part of her time to individual work and has an adequate supply of apparatus, such as small looms and different crafts, for bed patients.

In a mental hospital arrangements would have to be made according to the number of patients, design of the building and such local features. A convenient arrangement would be to have a large room for class occupation on both the male and female sides. A

series of smaller rooms for keeping apparatus and yet having sufficient space for two or three workers, should be arranged to serve convalescent and infirmary wards. If the nursing staff themselves are doing occupational therapy it will be possible and advisable to do considerably more of the work in the wards themselves. Obviously the arrangements should be such that the more recent admissions if curable should not have to mix with the chronic patients, and also that each group of patients working together be of the same degree of sociability and have the same appreciation of their external environment.

The personnel for occupational therapy should be fully-trained occupational therapists, of whom there are still comparatively few. An Association of Occupational Therapists [1] has recently been formed, and is getting out a syllabus of training for the purpose of taking their examination, which will probably form the standard for occupational therapists in England. At present only comparatively few places are making definite arrangements for the training of therapists.[2] Briefly, an occupational therapist should have some knowledge of, and have passed an examination in, anatomy, physiology, elementary psychology, mental disorders of all types and orthopædics. In addition they must have a really good knowledge of a reason-

[1] See Appendix. [2] See Appendix.

able number of crafts of the types that are mentioned further on.

One occupational therapist can manage to organize work for approximately thirty to fifty patients suffering from the neuroses and mild psychoses, but this does not enable a great deal of individual attention to be given. In a hospital devoted mostly to the psychoses where there are a large number of chronic patients, it is possible for the therapist to handle a considerably larger number of patients, as it is possible to arrange for them to do class work and less individual work is necessary. In places where occupational therapy is a regular part of the hospital life, it may be possible to take students who will help the therapist with the patients as part of their training. Another useful method of widening the scope of occupational therapy is to give a certain number of the nurses sufficient training in the crafts to enable them to work with and help the patients, which is far better nursing than to allow the impression to develop that they are just there to watch the patients while they work. Some authorities think that all fully trained mental nurses should have had a course in occupational therapy.

It should go without saying that like every other form of treatment, occupation should be prescribed by the physician, who should himself have sufficient knowledge to be able to judge what patient is going

to benefit and what type of work will help him most.

In considering the type of work which is suitable to any particular illness, it is helpful to divide the patients into groups. There are the mental defectives, the mal-adjusted children, the neuroses and milder psychoses, the more acute psychoses and the chronic psychoses.

The different crafts can be divided into:—

(a) Those that are automatic and need very little intelligence.

(b) Those that tend to produce a sense of order and rhythm.

(c) Those that need intelligence, reasoning, and especially stimulate an interest.

(d) Those that are mainly creative.

All crafts should have a purposive action and should as far as possible arouse interest and contact with reality.

The first two groups of crafts are mainly suitable for rather low-grade defectives, some of the chronic psychoses, such as advanced cases of dementia praecox, or even some degrees of organic dementia, some of the acute confusional psychoses or milder manics.

The crafts that are usually included in these two groups are hair picking, wool picking, washing and spinning, and perhaps even dyeing the wool: some

of the simpler forms of stool making, knotting and net making. It must be left largely to the knowledge and experience of the therapist to fit a craft which is both simple and yet purposive, for a difficult patient.

It can, for instance, be made a real interest to get wool from sheep possibly fed on the pastures of the hospital, and set a demented patient to work to prepare the wool for spinning, and it may even be possible to train that same patient, if he is not too demented, to start spinning the wool. This wool after being spun and dyed can be used by another patient for weaving. The making of stools can be simplified to suit rather restless patients who desire to use their physical energy. The wooden frames are made outside, and the patients simply build the seat of fibre or whatever material is to be used, and this needs a considerable amount of pulling. Knotting is quite a fascinating craft as coloured macramé string can be used, and such articles as belts or dog leads made. Clay work can be turned into a very soothing type of craft for acute patients, but the best work in clay modelling can be done by the patients who are less severely ill.

In the big mental hospitals where it is really necessary for a certain amount of the routine maintenance to be carried out by patients, a lot of the work can be carried out by the more chronic or demented patients. The cleaning,

polishing and tidying of the wards and the routine out-of-door work can all be made of excellent use. Care should be taken to avoid that any of the less demented or more highly educated patients, should think this drudgery, and all patients doing work, but particularly work of this character, should be given specified periods of exercise and amusement entirely different from their craft work, whatever it may be. For instance, most mental hospitals have a large chapel with a good organ and yet it is extraordinary how rarely the organ is made use of apart from actual services. It is probable that periodical organ recitals, the music being carefully and thoughtfully selected, would prove a great success amongst a lot of patients. This idea was carried out by a Chaplain in a big mental hospital with complete success.

The third and fourth sections of crafts are big ones: weaving, modelling, lettering, needlework, knitting, crochet, painting, carpentry, leatherwork, basketry and printing can all be included. Weaving is a particularly fine craft and is very good for men. All kinds of looms are used, from small hand looms which can be carried about and given to patients who are confined to bed, to large looms taking up a good deal of room, and needing the use of the feet as well as the hands. Setting up the looms is in itself a useful training in orderliness, and then the weaving can be simple or complicated. Simple patterns can

be followed by more complicated patterns, such as tartan scarves, while on the bigger looms material for clothes, rugs and mats can be designed and woven. This calls out intelligence, co-ordination and concentration, and is both interesting and purposive. Clay modelling is particularly good for anyone who needs to develop his creative faculties. Quite recently an introverted patient whose phantasy life was rich, and who was suffering from a typical attack of primary depression, was sent to the occupational room for treatment. He almost fell on the modelling clay, and within a few hours was doing some extremely fine work. On investigation it was found that he was artistic, fond of colour and form, but had never been allowed to develop the creative side of his life. All the creative instincts were being poured out into his phantasy life, which was not good. He had never learnt to make use of his phantasy and artistic self in a material or practical manner. This modelling gave him a new interest for the future. Moreover, it gave the psychiatrist an idea for helping him after his discharge from hospital. This patient was a departmental manager in a big store. He was one of the youngest managers and things were not going too smoothly. It was suggested, therefore, that he should work in the department which dealt with designing, window dressing, colour effects, and all those creative lines which aroused in him an interest that ordinary

departmental work had never done, and also it enabled him to make controlled use of his phantasy.

Another type of illness for which occupational therapy is excellent is writer's cramp. In addition to the anxiety state and psychological features which nearly always accompany this condition, there is invariably muscular spasm of the muscles of the forearm, particularly when any fast writing is attempted. In such a case the patient will be put on a craft which will sustain his interest, give him movements similar to writing and so not only re-educate the muscular movements, with the result that they occur without spasm, but in doing some craft with his bad hand the patient will gain confidence.

Printing, again, is excellent for stimulating and satisfying the creative side of an individual. The design can be drawn, cut out on a lino block, and the printing done on whatever material is chosen.

The above are but a few of the possibilities that present themselves.

It must be remembered that this form of treatment is still in its infancy and that much has still to be learnt. At the present time research work is going on to see if some specific occupation can be suited to definite illnesses. For instance, if an obsessional neurotic is given some weaving to do it may be possible to see the obsessional tendencies coming out in the pattern, and it is worth the attempt to see if in

some way pattern working cannot be used to help the patient to deal with his symptoms.

The work of the schizophrenics too is full of interest. Care must be taken to arrange their work in such a way as to avoid increasing their phantasy life and introversion. On the other hand, by giving them work which is creative, the use of their phantasy can be seen and to some extent 'harnessed' to a material use, thus getting them more in touch with reality.

Amongst children, occupational therapy, like play therapy, is used more to stimulate and satisfy some side of their life which has been repressed. It is marvellous to see how a child who has perhaps been brought for bad temper and rages, will sometimes quickly lose all tendency to get angry when able to develop some side of his nature which his parents have kept suppressed. One child in particular comes to mind. He was brought into the room by his father, struggling, kicking and screaming. He had to be held forcibly in order to prevent him from rushing from the room after his father had been sent out. Yet within a quarter of an hour that child and the physician were lying on the floor together drawing.

In addition to learning the actual crafts, it is necessary for occupational therapists to have a knowledge of exercises, eurhythmics, folk dancing, and ordinary dancing. The movements taught by the Margaret

Morris School are excellent in many ways. At this point there is a close connection with the physiotherapist, which should be fostered. Much gain can be given to patients by regular rhythmical exercises and music. Amongst some of the chronic mental hospital patients suitable exercises with correct respiratory action will help to produce a more orderly appearance if nothing else, and frequently it will bring them more into touch with reality again.

In a hospital dealing with the neuroses, it may be of use to get some of the younger patients together for a class of folk-dancing or organized exercises. It may help to get the right *esprit de corps* and social friendliness, which is so important in a hospital of that kind. At the same time great care must be taken not to cause any ungainly member of the class embarrassment, or to allow a sense of ridicule to creep in. If this occurs more harm than good can be done.

The very greatest use can be made of occupational therapy in private practice. Only those who have had long illness necessitating many weeks or months in bed or indoors can appreciate the difficulty in keeping the mind occupied and interested. One tires of reading and the eyes themselves get strained. If one is playing games there is the feeling that another person is giving up their time and that one is being selfish or a nuisance. An occupational therapist who could work a district just as a masseuse does, would

be invaluable. She could come to the house, sit with and instruct the patient in different crafts, changing them from time to time so as to maintain interest and exercise any muscle groups or joints, or help to keep the patient relaxed and quiet according to whatever medical instructions were given.

In large towns there is an opening for occupational centres[1] where not only the instruction of students is taken but also the treatment of out-patients. The additional value of such a centre is that the larger apparatus such as big looms will be there and so a greater variety of work can be carried out than in a patient's own home.

[1] See Appendix.

CHAPTER VII

FACTORS DETERMINING METHOD OF TREATMENT SELECTED

One of the most important decisions to make is what cases are suitable for any particular form of psychotherapy, because much harm can be done by submitting the patient to the wrong type of treatment. This principle applies particularly to analytical therapy, as it is possible to increase the patient's illness if the wrong type of case is chosen for this form of therapy. It is for this reason that it is vitally important that everyone practising psychotherapy should have really adequate clinical experience in the diagnosis of all forms of mental disorder.

An important consideration is that the patient should be sufficiently intelligent to be able to grasp the significance of mental mechanisms and psychological principles generally, and that he should not be too old to reform his ideas to some extent and make an adjustment to his newly found knowledge. It is useless to apply analytical technique to some poorly educated person who can barely speak the King's English, let alone understand the meaning of such

terms as the "unconscious mind," or "repression." Then the age of the patient must be considered. The longer an anxiety state has been going on, the harder is it as a rule to cure, though one freely admits that at times in the course of an analysis, even in a person of middle age, who has had an anxiety state for years, the bringing to consciousness of some repressed material, with consequent release of emotional tension, may produce a dramatic relief, or cure from the old state of anxiety. As a rough guide it is a good plan to consider very carefully the wisdom of starting anything more than a superficial analysis in a person who is over 40 to 45 years of age.

Unfortunately a feeling has crept in amongst some enthusiastic members of the community, and it is at times even implied by psychologists, that psychotherapy is like a magic wand, that it is only necessary to go on analysing the patient long enough to enable repressions to be freed, when hey presto! the symptoms will disappear and the patient be cured with no effort on the part of the patient himself. Most of us will sadly agree that this is hardly correct; the patient himself must do a great deal. For instance, if during the course of analysis an individual realizes that one of the main reasons why he could not get on with his fellow men is because he has had a bad temper, and that this temper was generated by fear of his father, and a feeling of rebel-

lion, it does not mean that the realization of all this in consciousness is going to make him free from all bad temper. He may have a considerable fight with himself to gain control over his temper. If then, a patient comes to a realization of some weakness or difficulty in his character and his adjustment to others, and yet will not make the effort to correct it, the analyst can do little more in that particular direction, and to a considerable extent the patient may remain as he was before.

This brings us to the next point that must be considered, namely the personality of the patient. The most ideal personality is the well-balanced extroverted type who is free from hereditary factors and who has a reasonable amount of initiative and purposive action in his whole make-up, and yet is not too extroverted to be able to be dependent on himself. It may be said that such a personality does not get an illness of a psychological type, and so does not need treatment, but this is not correct. Many a man who constitutionally has a good, well-balanced personality has, through faulty upbringing, developed symptoms which have cloaked the soundness of his personality. Moreover, the finest personalities may break down under sufficient mental stress. Anyone who is of the obsessive type of personality may be very difficult to analyse. Such a person will generally show very neat, methodical traits from childhood. He is exact and

pigeon-holes his ideas. He usually wants to know how everything happens, when everything happens, and where everything happens. In childhood he usually has played a lot of obsessive games, such as touching certain groups of palings when out for a walk, or stepping on or between the lines of flagstones. The schizoid, or schizophrenic personality, is one that does not lend itself to successful analysis as readily as it may seem to do. This is the shut-in, introverted type who is self-contained, not a good mixer and often having a rich phantasy life. In this type of personality it is not uncommon to find a certain lack of emotional backing. There may be a withdrawal from facing reality as if the patient was spoilt or indolent. The paranoid personality is also a very difficult type to analyse. Such an individual is also rather a shut-in personality. He is naturally suspicious, critical and always inclined to "project" far more than is normal. He is, therefore, always inclined to blame other people for anything that goes wrong, rather than to consider he himself may be at fault. Being critical he is much more ready to see faults in other people than in himself. He is rather the type to support forlorn causes and to take his stand with the down-trodden minority against the majority.

Another type of personality is the cyclothymic personality. In this the individual characteristically

suffers from mood swings. For no apparent reason the mood varies from one of elation when all is joyous, happy, and hopeful, to one of depression. People with a temperament of this type must be watched very carefully during an analysis for any increase of a depressed mood which may be a danger signal.

Though it has been suggested in the last few paragraphs that different types of personality vary in their suitability for analytical therapy, one must not make the mistake of thinking that, say, paranoid symptoms always mean a paranoid personality, any more than that a patient showing depression as a symptom is essentially a cyclothyme. Depression can often be secondary to other symptoms. The neurasthenic may get very depressed with his exhaustion and inability to get on with his work. An hysteric may show definite paranoid features owing to his resentment at being made to face up to the truth. In assessing the suitability of a personality for analysis, therefore, a broad view should be taken considering all the patient's life from childhood, school and adolescence to adult life. Moreover, if the history tends to show a very bad upbringing such as unjust parents, or favouritism at school, then these facts may be more indicative of the advisability of using analysis, for such an upbringing may have increased any mild personality traits, particularly the paranoid traits which the patient may have had.

Having satisfied oneself as to the suitability of the patient for analysis with regard to his age, intelligence and personality, the symptoms from which he is suffering must be considered. An anxiety neurosis or any anxiety state usually lends itself to analytical therapy. The very fact of being able to talk out his troubles often brings invaluable relief to a patient in a state of considerable anxiety. Then the analysis should proceed and go sufficiently deep to try and elucidate for the patient the early origin of his illness. If, for reasons already stated, analysis seems contra-indicated, the best plan is to allow the patient to talk out his troubles and worries and so far as possible get them 'off his chest,' discuss them with him on common-sense lines, using at the same time one's knowledge of psychology to try to clear up points that may never before have been clear. For instance, in an elderly or ignorant person, it is sometimes possible to bring great relief by explaining some point about sex concerning which they have always been ignorant. It is often possible, particularly when working among the poorer classes, to help correct their anxiety by adjusting their environment. It is worth bearing in mind that anxiety is the symptom for which bromide is of more use than perhaps any other. The treatment of anxiety states varies from deep analysis—the most curative form of therapy—to superficial analysis with re-education and medicinal help.

The hysteric is a rather more difficult problem. If, as is sometimes the case, the patient is suffering from some symptom which renders analytical treatment difficult, such as aphonia, or a paresis which prevents attendance at hospital, it is best to start with suggestion, probably in the most intensive form of hypnotism. If, on the other hand, the patient is suitable in other ways, and particularly if the onset of the illness is fairly acute, analysis can be begun at once. In analysing an hysteric, it is always advisable to remember the narcissistic background with which one is dealing. There is sometimes the danger of an hysteric using the psychological knowledge gained as a structure on which to build further symptoms, or a means by which situations can be created, sometimes between the doctor and relatives, or between the doctor and medical or nursing colleagues. It is often very helpful to make the analysis of an hysteric turn very largely on behaviour problems, and how they should have behaved under certain conditions. It is sometimes even worth while deliberately to create a situation so that the behaviour of the patient to that situation can be subsequently discussed with him. Perhaps the most difficult hysteric to treat is the middle-aged, rather chronic type, in which there are usually a number of physical symptoms rather than one 'conversion' symptom. These patients are often essentially selfish, fond of self-pity and

querulous. More often than not any attempt to show them their symptoms in the light of an emotional reaction, or mental process, is met with resentment, though in a few patients, even if not accepted at the time the psychological facts sink in, their significance is realized and the patients improve. Probably the best way of treating such hysterics is to take a rather particularly full history, allowing them to talk themselves out until they are dry. Then make an exceedingly full, careful and elaborate physical examination making it as impressive as possible with the whole idea of suggestion. During this time, and subsequently, every effort should be made to get *en rapport* with the patient, or in other words, to form a strong positive transference[1]. If this is done carefully and successfully, it may be possible then to point out to, and impress upon, the patient the fact that his symptoms are psychological, and not physical in origin and that if he can adjust his mental viewpoint and outlook on life then he will improve.

The patient who is suffering from an obsessional compulsion neurosis is occasionally one of the quickest and easiest of all patients to cure by analysis, but unfortunately, is more often one of the most difficult. The type of treatment must largely depend on the previous personality history. If there is a

[1] See Chapter II, Page 15.

definite history to show that the patient is of the obsessive personality and this is well shown from childhood, coming out in many ways then analysis is going to be difficult and, if undertaken, is probably best carried out along the lines of a true Freudian psycho-analysis. More often it is wiser to subject the patient to no more analysis than might be done in a very thorough, rather drawn-out history taking, then to explain the nature of his symptoms, their symbolic significance, and to reassure him on each of these symptoms. It is sometimes a real help if not a cure, for an obsessional to be told perfectly honestly that although he has the constant compulsion that he will, say kill his child, in point of fact he never will do so. At the same time every effort should be made to adjust any practical difficulties that may be facing him, and everything possible done to lessen mental tension.

This may, perhaps, be most easily illustrated by recording the treatment of an actual case. A girl aged 27 came to hospital complaining of intense obsessional thoughts and fears. She did not dare go out alone, and was particularly afraid of going up any height, or being left alone in a room because she felt that she would be impelled to throw herself out of a window. She also had impulses to injure or kill people. The origin of this last obsessional impulse was easily and rapidly traced back to an incident

which happened when she was a young girl, in which a friend of hers turned out to be a homosexual and upset her so much that on one occasion when they were walking together on a cliff she felt inclined to push the friend over. Unfortunately this recollection, even after explanation, failed to cure her, and she had to come into hospital. There appeared to be much more of psychological importance as she had been brought up by parents with very strong religious views, who had impressed them so unwisely on their daughter that she had got an entirely wrong and unhappy conception of religion. She was an introvert and would not talk much for some time, so much so, that it was questioned whether she was an early dementia praecox. Gradually, however, as a result of 'heart to heart' talks with little or no free association, and the patient always in the chair and not on the couch, it was possible to show her the mistakes that had been made in her upbringing, and to explain how they had affected her. The obsessional type of personality was explained to her, and then the reason for an increase of normal obsessional thought and action to an abnormal degree. The symbolic nature of pathological obsessions was illustrated and during all these talks she was encouraged to mix more, to take part in occupational therapy, and to play games. She was then taken out, encouraged to venture forth little distances from the Hospital by herself, and

finally to go up into high buildings. With this treatment she made sufficient improvement to go out from Hospital to live with relatives and take up work again.

True neurasthenia, that is an exhaustion state, lends itself to a mixture of physical treatment and psychotherapy. The latter should take the form of finding out what mental worries have contributed to the state of exhaustion and correcting these, which are fairly frequently practical worries or facts mostly in consciousness. In other words a superficial analysis is often all that is needed. For instance, this condition is more likely to occur amongst one's poorer class of patient and may be seen in a woman who has already had several children, has just given birth to another, has had to get up and start her housework within ten days of the birth, and has a husband who is bringing in only about £2 a week. In certain neurasthenics a deeper analysis may be needed as sexual factors may be involved, producing a greater degree of repression and hence more difficulty in reproducing the facts in consciousness.

Some of the most difficult cases for whom to decide treatment are the primary depressions or mild melancholics, and early schizophrenics. It is not uncommon to be asked by a general practitioner to see a patient with the chief idea of carrying out an analysis in such cases, and it is sometimes hard to convince relatives and the physician that analysis may not be wise.

Most authorities agree that it is not wise to analyse a melancholic, but there are some authorities who advise analysis and have reported successful cures. When the depression is slight the patient may appear only to be worried by his loss of interest and inability to concentrate; he may appear to show insight making it extremely tempting to start analysis, particularly if from remarks the patient makes, the physician is misled into thinking that the ideas of unworthiness so typical of all melancholics, are actual psychological facts which are worrying and distressing the patient and causing him a sense of guilt. It is essential to realize that although it is always possible that a melancholic may divulge some real sin that has been worrying him, his ideas of unworthiness rarely have any psychological significance at all, and are a rationalization to explain away his depression.

If the analysis of a melancholic is undertaken there is a grave risk that he will be made more introspective more morbid than he already is, and so will become actively suicidal. When one has attempted to carry out analysis of a melancholic for the purpose of investigation and research in a mental hospital it has been disappointing to see a recurrence of depression perhaps several years after treatment, even though during the treatment the patient may have appeared to improve and respond to analysis. It is not uncommon to find that the melancholics do undergo spon-

taneous improvement and recovery, and, if this occurs, as it frequently does, during some particular treatment that is being given, it is naturally very easy to say that that treatment is the cause of the improvement, and only when recurrence occurs perhaps years later, is it appreciated that it was a spontaneous recovery, rather than a specific cure.

The psychological approach to the melancholic then should be one of absolute patience, sympathy and understanding yet mixed with the right type of firmness. He should be treated with the maximum amount of positive suggestion and reassurance as to his recovery. His ideas of unworthiness should be listened to, and it should be explained to him that the reason he lays such emphasis on what are actually trivial sins is because it is typical of the illness that the patient becomes self-accusatory and that it is as natural for that symptom to occur as say, a cough in a case of bronchitis. If he has sufficient intelligence and knowledge explain to him that these ideas are a rationalization to explain away his depression. At the same time if what appears to be a genuine sin crops up which is worrying the patient, it should be dealt with, the degree of sin reasoned out with the patient and the question of confession, repentance and what to do made clear according to the individuality of the patient concerned. The typical feeling of hopelessness should be treated by constant

reassurance with again the explanation that this horror is a common symptom. Where a naturally religious patient has the feeling that he is damned and that God has left him, he must again be reassured, and it can be really helpful in some cases to get a wise clergyman who has an understanding of such cases and so can lend his weight to the mass of suggestion. Every attempt should be made to arouse the interest again, and so start the ability to concentrate, by occupational therapy. The idea that this interest can be aroused by 'taking the patient out of himself' which means taking him around to entertainments and parties, is of course, all wrong. A routine type of life is good, and if the depression is not too bad to prevent the patient from carrying out his usual occupations it is perfectly justifiable to allow him to continue at his work.

In the manic phase of the manic-depressive psychoses the patient is unlikely to be sufficiently co-operative to make analysis possible even if it is advisable. It has been suggested by some authorities that in the manic-depressive psychoses no analysis should be attempted while the patient shows any symptoms, but that if analysis is carried out in the normal phase, further attacks may be preventable. This is not yet generally accepted.

Just as with the mild depressions so with some of the less severe schizophrenics, whether they be very

early cases of dementia praecox, or else mild paranoiacs, so it is extremely tempting to analyse, but again the most general opinion is that it is the incorrect method of treatment. Again there are authorities who have recorded cures or amelioration of the symptoms of schizophrenics. There is probably not so much danger in analysing these patients as there is with the depressives. By analysis with free association a schizophrenic may be made more introverted and so more liable to live in his own phantasy, or a paranoid type, or paranoia, may become extremely hostile to the analyst.

The more common experience is that hours are spent listening to material that may in part be phantasy and that tends to be repeated, and when an attempt is made to explain and reconstruct, it is all too frequent to find that although one's words are politely listened to, they do not appear to have the slightest fundamental effect, and one gets the impression of talking into a wall of cotton wool. If analytical technique is to be adopted towards a schizophrenic it is probable that the Jungian method is the more likely to succeed. The Jungian analyst is more able to keep in touch with him than the Freudian, and by working through his dreams and correlating them up with his phantasy life, the analyst may be successful in bringing the patient 'down from the clouds,' and so put him more in touch with reality.

The Jungian technique is particularly adaptable to that class of people who are usually dubbed psychic or mediumistic, who do as a rule show the schizophrenic personality rather more than any other type. The Jungian shows appreciation of mysticism, and a broadmindedness to some of these most abstruse mental processes particularly well.

There is no special psychological approach when talking to a schizophrenic. It is right to listen to his symptoms, to explain them to him in terms of consciousness, and to point out to him the significance of phantasy and symbolism. This only applies if the patient is sufficiently in touch with reality to be acessible and co-operative. There is some evidence that through occupational therapy the phantasy life can be explored, which may lead the physician to a clearer understanding of the mental processes involved. At present, however, this is much more in the nature of research work, and cannot be described as curative.

At the present time the treatment of schizophrenia is thought of in terms of shock therapy. Either the patient is given insulin shock[1] in which sufficiently large doses of insulin are given on alternate days to produce a state of coma, anything up to forty or even more treatments being given, or else cardiazol in a 10 per cent sterile solution is given intravenously.[2]

[1] See Bibliography. [2] See Bibliography.

Anything up to twenty injections of cardiazol are given, not more than two injections a week, being the usual rule. However, even though these forms of physical treatment are given, it has been advised by some authorities that the patient should be carefully observed during the semi-conscious stage through which they pass in both forms of treatment so that any psychological material which comes out may be made use of in subsequent interviews with the patient. It is worth stressing the fact that psychotherapy can be combined with many forms of physical treatment and this should never be forgotten. Palmer writing on prolonged narcosis[3] mentions the importance of getting the right contact between the patient and both his physician and nurses, also of giving positive suggestion whenever the patient is awake throughout the treatment.

An absolutely honest and yet sympathetic attitude is particularly essential with a paranoia. Delusions must never be agreed with, nor must they be ridiculed or spurned. It is useless to reason with the patient and to try to convince him that he is wrong by reasoning. It is wisest to listen to what the patient has to say and gravely agree to differ. In fact, treat the patient as you would a particularly touchy colleague who holds a different point of view to yourself

[3] See Bibliography.

on some subject; indicate that while you respect his view you do not agree.

Persons suffering from confusional states, whether the result of alcohol or some toxic focus, are not usually accessible, so the possibility of analysis need not be considered. It is important, however, to remember that in these confusional states there is often some mental stress at the back. Where, therefore, the confusion is not too bad, the patient should be treated with suggestion and reassurance. This is particularly important where the hallucinations are of a terrifying character. Everything should be done to allay the fear by explaining that the phenomena are symptoms. It is not wasting time to spend quite a long period, 15 to 30 minutes every day, or even two or three times a day, with a mildly confused patient, reiterating to him that the voices he hears or the visions he sees, are part of his illness, are just symptoms, and will disappear as he gets better. It may be even possible to go a little further and get across to the patient that it is like delirium. Then when the confusion is clearing or cleared, a superficial psychological investigation should be made in an attempt to elicit any psychological problems. Opportunity should also be taken to explain to the patient what he has been through, and that the hallucinations were a symptom. This explanation is only necessary if he has a partial realization of what

he has been through. If the confusion has been so great that there is complete amnesia for the period, it is probably wiser not to attempt to make the patient aware of what he has passed through.

In organic conditions giving rise to mental disturbance analytical psychotherapy is not indicated. At the same time it is evident that even in organic illnesses of all kinds there is almost certainly some percentage of a psychological upset so that the whole illness can be helped by suggestion, reassurance and such methods. Epilepsy is a condition which some authorities have said can be cured by analysis. To assess the truth and value of this statement one must realize that epileptic fits should be regarded more as a symptom. Where a demonstrable organic basis such as a tumour or arteriosclerosis is found, obviously analysis is useless. The group of fits which occur in hysterics may be at times indistinguishable from those with an organic basis, but should of course, be treated analytically. Finally in the so-called idiopathic group of cases, even though the typical epileptic temperament may suggest some psychogenic factor, analysis is rarely of any curative value.

It is unnecessary to say that in this chapter only the psychological treatment available has been discussed, little or no mention having been made of any physical treatment that can be, and is, used in certain

cases or for special symptoms. For instance, with regard to confusional states no mention has been made purposely of the eradication of the toxic focus nor of the importance of sedatives for the insomnia commonly seen in depressives.

Nor has the use of occupational therapy been mentioned in every case, although it is usually applicable, as already stated.

CHAPTER VIII

CHILD GUIDANCE

Perhaps the greatest use and at the same time the chief fascination of psychotherapy lies in what is commonly termed child guidance. This is really the correct building up of the child's character to form the best type of adult.

Freud's work showed how vastly important it is to bring up a child moulding its character along correct psychological lines. He showed how many symptoms seen in the neuroses, and probably in the psychoses also, are directly attributable to mistakes made by parents and others in the education of children. This observation has been abundantly borne out by every school of thought. It is generally agreed now that it is the first seven years of life which are most important for training and developing the best and finest type of character.

From this point of view psychotherapy is extremely important in prophylactic medicine. If, by educating doctors and the public in the correct psychological principles on which character is formed, it is going to be possible to lessen the amount of mental illness in

the world, a great achievement will have been gained. It is only necessary to consider the vast expense to the State and industry that mental illness has become to-day, to realize the urgent need for prophylaxis in this type of illness.

It is hardly within the scope of this book to give schemes for developing the prophylactic value of psychotherapy, but mention is made of this in Chapter IX. The use of psychotherapy in children who are already showing symptoms will, therefore, be dealt with here.

The mode of attack differs a little according to the social scale and financial resources of the patient. With private patients the physician may feel inclined to do most of the psychotherapy himself with each child, or to remove the child into an entirely fresh environment, but in the child guidance clinics where large numbers of poor children are being dealt with, this is not possible. Each clinic is composed of three main units, the physician, the psychiatric social worker, and the lay or educational psychologist. This team may be supplemented by various other workers, but these three units are the essentials.

The child is usually first seen by the physician, who, according to his own particular technique may see the parents before or after seeing the child. In the preliminary examination all physical factors are excluded by an adequate examination unless this has

already been done elsewhere. During the preliminary and physical examination every effort is made to make good contact with the child and to gain his confidence. It is often possible at the same time to sum up to a considerable extent the main roots of the child's trouble, such as an over stern father, a doting mother, or incorrect discipline.

Frequently several interviews with the child are needed before his confidence is gained. On the other hand real sympathy and evidence of affection on the part of the physician will loosen the flood-gates, and out will pour the pent-up emotions and trouble which the young mind has never been able to share with anyone before. The methods of making contact with a child, getting its history, and assessing the whole situation must obviously differ a good deal from those used with adults. In the first instance it is probably best to find out what are the child's interests or hobbies, or if it is too young for that, simply to observe its behaviour and reactions under different situations. Sitting chatting with the child, taking it round the building to show it things, or playing games may all lead on to the true emotional reaction of the child to life whether it be fear, anger, resentment or a mixture. The attitude of the child to the parents, brothers sisters and friends, should all be found out either by question and answer or by the use of the physician's observations. It is often very

instructive to watch the child with one, or both of its parents and in this connection the visits of the psychiatric social worker to the child's home are invaluable. Even in the clinic itself much information can be gained. There is the over proud mother who will be prompting her child the whole time, giving its arm a shake, saying 'Speak up, Willie, answer the doctor nicely,' etc. Then there is the mother who is obviously so worried that she is projecting all her anxiety on to her child. Quite without insight she may say in front of the child, 'He is so naughty he is getting on my nerves ; he will make me ill soon.' The father who believes in real discipline is another type of parent, often a man in one of the Services, or in the Police Force. He believes that to strike fear into the heart of the child is the correct manner in which to make the child obedient and brave, and he treats his child rather like the proverbial sergeant-major treats his raw recruits.

The behaviour of the parents towards the child must be noted, and it is as important to make good contact with the parents as with the child, for the real cure lies so much in their own hands, and no parents like to be told that they are bringing up their child in the wrong manner, and that the illness is in some ways their fault because of this. It is essential, therefore, to be on the friendliest terms with the parents in order to be able to explain, without

causing offence, the root of the trouble and how they should remedy it.

In some children who are introverts and quite unable to make contact, it may be the best plan to send them to the play therapy room. This room should be fairly large, with either large, low blackboards for drawing, or else it should have the lower part of the walls covered with some substance on which a child can draw or write. There should be a certain number of toys, the use of which is obvious to a child, such as a rocking-horse, also toys such as bricks and building material or Meccano, the use of which calls out a child's intellectual capacities. A sand pit is excellent if there is the room for it. A clear space is needed, or even a separate room, in which a child can be left to his own devices, only such material being at hand as would enable the normal child to occupy himself and give evidence of his instinctive ability, and his power to create occupation and interest for himself. In fact the play therapy room should be designed so as to give children of all types the chance of finding some object of interest and some outlet for their instinctive reactions and innate interests.

The play therapy room has many uses. Its simplest use may be to obtain an atmosphere of friendliness and happiness so that the child may feel at home. The child may go into the room with the physician,

who himself will play with the child, or the child may go in with a number of other children who are themselves old patients and at home there.

The most important uses of this room are to test the child's reaction to its play, to the other children, and to the toys. It is also extremely important to see the child's natural abilities and interests. Sometimes the whole of the child's troubles may be found to lie in the fact that the parents have dammed back his innate urges, such as music or art, and have attempted to develop some other side of the child's intellect which is just not there to the extent that they had hoped.

In the same way repressed instinctive tendencies may show themselves in destructiveness, too great a desire for acquisition, undue curiosity, and many other traits. For instance, the small child who is inclined to hoard to the point of pilfering may well be a child of hard parents who have never given him much affection, who have rarely bought him presents, or little surprises so dear to the heart of all of us when we were children. Again, the children who have had discipline and religion thrust down their throats too much, often, sadly to say, the children of well-meaning but misguided religious folk, may revolt against that very spirit of discipline and religion by such an act as petty theft, becoming the rebel type and challenging authority. By watching the child's behaviour towards

the other children much information can be gained. It will be possible to see if he is an introvert or extrovert, if his fear reactions are excessive and he has a bad sense of inferiority, or if he has been over protected and so is afraid to stand up for himself. All kinds of natural traits may be seen and many indications as to how his instinctive actions have been dealt with, whether modified wisely, or dammed back and distorted.

Another use of play therapy is to help the child to sublimate some of his instinctive urges, and this naturally will help his creative tendencies. It will be realized that at this point, play therapy and occupational therapy are aiming at the same goal, and this is mentioned in Chapter VI.

A child who has been giving trouble at home through excessive curiosity with regard to sexual matters or who has got into trouble through playing sexual games with other children may perhaps be found to have a large creative side to his make up. His introduction to the play therapy room may lead him to play with sand, modelling clay or fret-saw work, and the opening up of this new vista may well enable him to sublimate his past troubles. From the rather troublesome small boy with the 'dirty mind' who was brought in, emerges a perfectly normal healthy young soul, who will illustrate his creative abilities by modelling, drawings, or carpentry, It is

impossible in a book of this type to give all the many useful bits of information that may be gained from the play therapy room, but what has been written will give an idea of the work that is aimed at in the majority of them. The child will always be unobtrusively observed while in the play room, either by the physician himself, or else by one of the lay workers. A peep hole into the play room is used at some clinics.

As soon as good contact has been made with the child, it is important to assess his intellectual capacity, and for this purpose an intelligence test is carried out. This is the special work of the educational psychologist. If the child has reached school age, is in a high form and getting really good reports as to his intellectual abilities, it is not essential to carry out such a test. There are a number of methods devised for the purpose of intelligence testing, such as Binet-Simon's tests, or the Stanford revision of these tests which Terman recommends, and the Northumberland tests.[1] The rationale is the same in each case. There are a definite number of tests, some theoretical, some practical, and it is known that a child of normal intelligence ought to be able to carry out a certain number of these tests perfectly correctly. Some in part only, and other tests not at all, according to his age. The child is put through

[1] See Bibliography.

the tests, and in accordance with the marks scored so is his intellectual age reckoned. The index of intelligence is given by putting the child's intellectual age over his chronological age, and expressing it in terms of percentage. This is called the child's intelligence quotient or I.Q. For instance if a child of 10 years old does the tests in such a way as would have been expected from a normal 12 years old, his I.Q. would be $\frac{12}{10}$ or 120. It has been found that children getting an I.Q. of much under 75 are usually mental defectives, and therefore need especial treatment.

It must be stressed that intelligence testing must be taken with a broad view, as there are many fallacies. The more experienced the psychologist, the more likely are the results to be accurate, as she will take into account the vagaries of individual children, their emotional reactions and particular bents, and she will probably work within reason to a standard of her own which would give more accurate results over a long series of cases than if different psychologists were carrying out the tests.

During the time that the preliminary investigations and contacts are being made with the child, the physician and his psychiatric social worker see the parents. The physician himself should have one or more interviews with the parents, at first to hear their point of view, then to assess to what degree it is their

upbringing of the child that has caused the trouble, and also to what extent they are capable of appreciating the situation and changing their attitude of mind, so that they can co-operate in the future. At a later date the parents must have all the various mechanisms explained to them, and they must learn how to avoid the errors into which they have fallen. They must learn that they themselves must live the type of life which they desire their children to live, and that the basis of character formation is true, unselfish love, affection and sympathy. The correct method of inculcating discipline by modification of instinctive urges without damming them back must be taught. The dangers of spoiling, producing a fixation, or disciplining by fear must all be explained to the parents. Some physicians leave all this to the psychiatric social worker, but it is better clinically for the two to work in close co-operation. The psychiatric social worker should know the child, and can make contact in, say, the play room ; she should also know the parents and should visit their home. In this way she is able to make a report on the patient's environment, the sort of home he has and how the parents keep the home. She should meet any siblings or other residents in the child's home, and so be able to provide for the physician a completed picture of the child's whole life and background. This work is of inestimable importance and in a busy clinic

enables an immense amount more work to be got through with efficiency. As the treatment of the child and the education of the parents progress, the social worker may help in other ways, by opening out a better and newer type of life for the child. In older children especially, change of work, fitting them into a change of environment, even starting them on a career, may all be undertaken. This again is dealt with in a little more detail in Chapter IV.

It can be seen that in child guidance work the problems are attacked from every angle, and the whole situation dealt with, rather than concentrating on the little patient alone.

It is not always easy to get across to the parents of rather poor education such information as the mental mechanisms, or what is the meaning of instinctive behaviour. The following is usually understood and accepted quite fairly well. 'It is generally agreed that all of us are born with a certain number of instincts. By the word instincts I do not mean quite the same as we do in ordinary everyday life when we say "I put out my hand instinctively." When I use the word instinct here I mean that we are all born with a tendency to act in a particular way under particular circumstances without ever having been taught how to do so. I can make this clearer by an example. Take what we call the nutritional or feeding instinct. A few hours after birth the new-born child begins to

show signs of distress and discomfort; the mother or the nurse knows it is hungry and it is put to the breast whereupon it immediately begins to suck. It has never been shown or taught how to suck, it is an instinctive action. It is not certain yet how many instincts there are, but they are broadly divided up into self-preservative instincts, that is for keeping ourselves safe and free from danger or death, and the reproductive instincts which are for the purpose of men and women mating, and so keeping the race going. It must not be thought that the instincts are completely and perfectly developed at birth, far from it, they merely provide the driving force which makes us act and do things in our lives. The child sucks the breast certainly, but in a clumsy, greedy manner. He has to be taught to suck slowly and steadily, later to suck from a teat, then from a spoon and cup, and later to take solids. He has to be taught when rather older not to be too greedy, and so gradually month after month, as the child grows the instinct is modified. It is this modification of the instincts which is the correct way to begin to give discipline. As I have said, the instincts give the driving force to life, they make us want to do well in life, to go one better than the other person, to get money and a home togther and so on, and it is in the modification of these driving forces in order to prevent selfishness, greed and too great a drive for

power that so much care is needed from you parents. Too many parents try to make their children live their lives along the lines that the parents want instead of helping the children to live their lives along their own lines, guiding and helping them to do this in the best possible way. It is most important to help the child to develop healthily by learning to modify the instinctive urges and drive, but not to restrain them unduly. If an instinct is thwarted and frustrated, its energy is like a river that is dammed back, it will go on gathering force behind the dam until it overflows its banks and makes fresh channels. If, for instance, a child has strong creative urges and is always wanting to draw or paint or make something, and is constantly stopped, then that urge which has been stopped will come out in some other way such as in rebellion and naughtiness.'

It is also sometimes necessary to explain to parents some of the mental mechanisms, and these again must be put in the simplest words. Projection can be explained in such words as these: 'We all know how hard and unpleasant it is to admit our own faults and that we are only too ready to see similar faults to our own in other people. Well, in addition to this we sometimes have something in our unconscious mind which is causing us a lot of emotion such as anxiety, anger, or unhappiness, and yet because the real cause is in our unconscious mind we

do not realize the true cause of this emotion, and so fix or project it on someone or something else. If I have had a good day, the work has gone well and I feel that I have helped the patients, and when I come home one of my children runs to welcome me and in so doing knocks off my hat, I probably just say "Steady old girl, not too rough." On another occasion, however, the child does just the same thing, but I am coming in after a bad day when things have all gone wrong, and I am really annoyed with myself at having made a mess of things with one or two of my patients. Instead of speaking to the child as before I flare up and say "Do be careful; you have knocked my hat in the mud and ruined it, how rough you are!" On this second occasion I am projecting the emotion which is the result of anger at myself on to my child.'

Over-compensation may be more easily explained by saying that if we feel we have a defect in some way we try to make up for it and in some cases our efforts are such that we overdo it. For instance, the individual who is really very shy, may, when he is at a party try to hide up his shyness by being particularly gay and hearty and if he overdoes this, or over-compensates, he becomes loud, noisy and boisterous. A boastful child may well be one with a bad sense of inferiority for which he is over-compensating.

A parent must also realize what a vivid phantasy

life many children have and how vividly their imagination may run riot, and what an important part this may play in telling lies.

Should it be found when the intelligence testing is done that the child has such a low I.Q. as to indicate a mental defect the procedure must be rather different. Under such circumstances it is only correct to assume that the child cannot learn or form character in the normal way. Especial education and training must be provided. In wealthy families a mixture of individual teaching with group teaching is probably best, so that while the child's character and intellect get especial help, he is not cut off from contact with his fellow beings and children of his own age. Amongst the poorer classes special schools are provided for the education of the feebleminded or backward child, but even in these schools more attention is paid to developing the intellect than the character. If the I.Q. is so low as to indicate that the child is not educable, the only plan is to have an especial arrangement at home, or with a few others, and devote particular attention to character formation and development along practical lines, or else to send him to a colony. The colonies make a great deal of use of occupational therapy for the purpose of training defectives and keeping them employed. In some cases the educational psychologist must be called in. This is necessary with backward children, or

where there is such mal-adjustment that a child cannot get on at school and with other children or in such difficult cases as the child who is born deaf or blind. It is invaluable to give specialized education for which an educational psychologist's special knowledge particularly fits her. A large part of her time is spent in teaching, in order to help the difficult child, and all sorts of schemes are evolved for this purpose.

Although it is the more usual policy to try to interpret what is wrong with the child by watching his reactions to life, seeing his parents, and then making deductions from which corrective measures are instituted, there are a certain number of authorities who believe in a deeper analysis.

The deeper analysis of children may be carried out by the use of the play room. The child's play and reactions are noted very carefully, and then he is asked why he did such and such a thing, and his chain of thought is investigated. Particular attention is paid to the association of ideas, and every effort is made to correlate up articles or toys with which a child particularly likes playing, with his more instinctive life, so that a greater knowledge of his unconscious is gained both by the observer and the child himself.

His phantasy life is studied very carefully in an attempt to detect such processes as anal eroticism, castration fears or an oedipus situation. If a parti-

cular unconscious process becomes clearly evident, there are some who think that it should be opened out and discussed with the child quite freely.

Some authorities claim that working along these lines it is possible to foretell that a particular child is building up his character and learning to react to life, in such a way that he will become say, a schizophrenic or manic-depressive. The claim that such an early diagnosis is possible is not generally accepted, nor is the contention that by the analysis of small children it is possible to stabilize the character to such a degree that no psychotic illness will ever develop.

In conclusion it is worth while to point out what an invaluable aid it is for a child guidance clinic to have really reliable information concerning foster homes and foster parents.[1] In some cases the home surroundings and parents of the child are so impossible that it is essential to remove the child to a fresh environment where he can get the motherly love and affection so essential for proper character development.

[1] See Appendix.

CHAPTER IX

PSYCHOTHERAPY AND PROPHYLAXIS

In the previous chapters mention has been made on several occasions of the value of psychotherapy in preventing mental disorder. In this chapter an attempt will be made to indicate some ways in which the application of psychological knowledge can be used prophylactically.

If one assumes that much that has been learnt by analytical methods is correct, and that a great deal can be done to prevent the development of the neuroses by paying due attention to the formation of the child's character and applying modern knowledge to it, then obviously everything possible must be done to spread and enforce that knowledge.

The public must be given greater psychological knowledge, because it is they who are the parents; the medical profession must be able to give the knowledge to the parents just as they now give physical knowledge. Schoolmasters must pay as much attention to character formation as intellectual education, and children's nurses must have all the knowledge possible on the subject.

Up to the present time very little teaching on these matters is included in the medical curriculum, although matters have improved recently. It is probably better taught as a post-graduate study. It would give an impetus to the whole movement if examining bodies included questions on this topic in the final examinations, also if the various teaching hospitals and centres provided more adequate arrangements for post-graduates to obtain the necessary clinical and theoretical experience.

The public are going to learn about it from their general practitioners, who will stress the importance of it when the mother is attended for child-birth; the rest can be done by books and public lectures. All ante-natal clinics would do well to provide instruction on this topic, and in the larger teaching hospitals there should be close co-operation between the children's and the ante-natal departments, and the department for psychological medicine. Pamphlets can be issued, just as dietary instructions are issued in a pamphlet in a diabetic clinic.

It has been amazing that in nearly every training college for children's nurses, practically no allowance has been made for instruction in psychology, and the importance of character formation. Only recently have a few nursery colleges arranged such a course in their syllabus. It is tragic to see the blunders that nurses, who are in other ways excellent, make over

trying to form a child's character. It is also incredible that so many parents will entrust their children to someone who has never had any training or guidance in looking after children. Every nursery college should arrange an adequate course of lectures on child psychology, and if possible a short attendance at a child guidance clinic would be invaluable. Parents should insist on nurses who have some knowledge of character formation as well as dietary and physical health.

Schoolmasters can get a lot of knowledge from books, but there should be more open encouragement to them to bring the question of character formation to the forefront. It is encouraging to know that the Preparatory Schoolmasters' Association recently sponsored a brief course for masters on this subject. If parents have given of their best in bringing up their children in the correct way during the first seven years of those children's lives, surely they have the right to expect that the work shall be carried on in an equally correct manner during school years.

In religion too, the need for a wider knowledge of psychology is being felt. Many of the problems concerning the soul that are brought to clergymen are due to mental illness or psychological upset, and the clergy themselves are asking for guidance in this matter. Moreover, it is the duty of Christians not to stand still, but to see religious doctrine in the light

of new knowledge. Again, it is a hopeful sign that work is being done at the present time in the Church of England to investigate this need, and to attempt to bring together clergymen and doctors in a mutual endeavour to increase the art of healing.

It must be obvious from what has already been written that much of the preventative work that psychotherapy dictates runs side by side with social reform, such as the unemployment question, social economics and several others. It is hardly possible in a brief work of this kind to go into such matters. However, anyone who is taking up psychotherapy ought to have a real acquaintance with these problems, otherwise he will not be able to handle his patients with that sympathy that is so essential. Specialists are often criticized and rightly too, for seeing problems from only one angle—that of their speciality. There does seem to be no doubt, however, that without trying to 'psychologize' the world, it is essential if the mental health of the nation is going to be maintained and improved that authorities should realize that the whole question of social reform, improvement of unemployment, freedom from poverty, avoidance of long continued pressure of work and unsuitable employment must all be considered from the point of view of the individual's psychology. Fortunately the human seems to have an immense ability to adapt himself to external

environment, but only if his mental balance is good. This means that if his instinctive life has been frustrated and inhibited too much, and that the unconscious conflicts are too great, he will not stand up against the difficulties of his external environment. The importance must be faced of correcting the sexual life of the nation, of trying to help the women who are in excess of the men in their loneliness and inability to fulfil instinctive functions. Few realize the curse of loneliness to-day, the number of women who are living in a room by themselves earning a meagre living and unable to open out their lives at all. The opening of clubs or social organizations to help these lonely individuals to sublimate their instinctive energies is all valuable and preventative work, but even more important is it to get back to the vital principle of bringing up our children to adapt themselves to circumstances and to create a better and healthier world.

It might be helpful to try to summarize to some extent the points which most often seem to crop up in dealing with children, and the instruction that should be given to prevent such mistakes.

(1) Parents fail to realize the suggestibility of children and hence by suggestion pass on their own faults and errors. Too many parents expect that their children must live a model type of life, while they can do what they please. A good example is

swearing. Parents often swear themselves but expect their children not to do so.

(2) Parents show too little real, unselfish love and affection. Only too often it is thought adequate to give affection just when it is convenient to do so. Small children know amazingly quickly when their parent's love is sufficiently deep and genuine to be truly unselfish.

(3) Through pride parents try to make the perfect child, instead of aiming at the perfect adult. The child should be permitted to pass through its natural phases, such as untidiness, a tendency to tell lies, or noisyness, without too much correction, as each phase will naturally pass.

(4) Parents project their own emotional reactions on to the child.

(5) Parents either fail to discipline the child, or discipline the child in the wrong way. In disciplining a child, do not punish it too much for its natural phases through which it should pass. A child tells lies either through phantasy or fear in the majority of cases. In both these instances the phase will pass. Only about puberty does a child begin to appreciate cleanliness, and have a desire to become tidy and adorn himself. Any childish action, which is the direct outcome of an instinct—and after all most of their actions have such a motive—should be modified when necessary but not dammed back. Teach

children by all means to be unselfish, thoughtful for others, to have good manners and to develop self-control, but let it be inculcated into them, a gradual process of leavening, not the 'mailed fist.'

(6) Parents should never discipline by causing a child deliberate fear. The primary emotion of fear which is innate causes us much trouble as it is, and it is no longer so necessary for the preservation of life as it was in more primitive times. Every effort should be made to decrease the sense of fear in children.

(7) Parents often neglect to give the natural instinctive tendencies of a child freedom to develop. Too often they want to lead the child's life for it, rather than to stand aside and help the child develop its own life.

(8) Sometimes the child is protected too much, is never allowed to stand on his own or to make his own decisions. A parent must realize that more harm can be done psychologically by over-safeguarding a child than will ever result from a few bumps and bruises.

(9) Parents often fail to help the child with the development of his sexual instinct. One group of parents tell the child nothing and allow him to find out about it himself in the best way that he can. A second group of parents, through a sense of duty, feel that they should tell their child something about the 'facts of life,' but do so with so much awkwardness

and embarrassment that their emotional reaction is projected on to the child. A third group of parents instruct adequately and well. They allow their children to grow up intimately with them, knowing and appreciating each other's physique and bodies. They allow no sense of shame to creep in over natural functions. They answer questions truthfully and simply as they are asked by their children, probably repeating the instruction in rather different language at different ages as the child forgets the earlier questions and answers, and often repeats his queries at later stages. Parents should try to get their own ideas and emotions so clear about sexual problems that they can talk about them perfectly naturally.

It is probably worth while to attempt to stabilize personality traits, though some authorities might say that as they are innate they are bound to exist. The child who is an introvert should be helped and encouraged to make external contacts, to widen out his social interests and so make himself more of the extrovert. The child who from an early age is tidy, exact, and inclined to show obsessional traits should not have that side stressed. In fact some carelessness and a free and easy attitude towards things should be encouraged. The child who has a rich phantasy life should be helped to harness his phantasy to reality. He should not be scolded or punished because his phantasy runs away with him perhaps making

him tell lies. He should be guided to use his phantasy in some creative manner, whether it be drawing, painting, carpentry or modelling. Greater advantage perhaps should be taken of vocational guidance tests.

This brief chapter may indicate that a knowledge of the psychological processes is essential in handling the problem of a nation's mental health, while in no way belittling physical factors.

APPENDIX

Post-graduate instruction for the purpose of diagnosis can be obtained in the Out-Patient Departments of many teaching hospitals. St. Thomas's Hospital is carrying out post-graduate teaching in Out-patients. The Maudsley Hospital, Denmark Hill, both during the course of instruction for the Diploma of Psychological Medicine and at other times, provides instruction. The Institute of Medical Psychology, Malet Place, W.C.1, particularly gives instruction in all methods of psychotherapy.

Particulars concerning occupational therapy can be obtained from the Secretary, Association of Occupational Therapists, c/o G. E. Holt & Son, Victoria House, Southampton Row, W.C.1.

The two recognized training centres are the Occupational Therapy Centre, 26, Great Ormond Street, W.C.1, and Dr. Elizabeth Casson, Dorset House, Clifton Downs, Bristol.

Vocational Guidance Tests can be carried out at the Institute of Industrial Psychology, Aldwych House, Aldwych, W.C.2.

The Child Guidance Council keep a register of foster homes and give invaluable aid on any problem connected with child guidance. All information can be obtained by writing to the Secretary, Child Guidance Council, 210, Victoria House, W.C.1.

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